

105TH CONGRESS  
2D SESSION

**H. R. 4250**

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**AN ACT**

To provide new patient protections under group  
health plans.

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## AN ACT

To provide new patient protections under group health plans.

1       *Be it enacted by the Senate and House of Representa-*  
2   *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—The Act may be cited as the  
3 “Patient Protection Act of 1998”.

4 (b) TABLE OF CONTENTS.—The table of contents is  
5 as follows:

Sec. 1. Short title and table of contents.

**TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT  
INCOME SECURITY ACT OF 1974**

**Subtitle A—Patient Protections**

Sec. 1001. Patient access to unrestricted medical advice, emergency medical  
care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

**Subtitle B—Patient Access to Information**

Sec. 1101. Patient access to information regarding plan coverage, managed  
care procedures, health care providers, and quality of medical  
care.

Sec. 1102. Effective date.

**Subtitle C—New Procedures and Access to Courts for Grievances Arising  
under Group Health Plans**

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

**Subtitle D—Affordable Health Coverage for Employees of Small Businesses**

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrange-  
ments.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

**TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT**

**Subtitle A—Patient Protections and Point of Service Coverage Requirements**

Sec. 2001. Patient access to unrestricted medical advice, emergency medical  
care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-  
of-service coverage.

**Subtitle B—Patient Access to Information**

### 3

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Effective date.

#### Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

#### SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

### TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

#### Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

#### Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Effective date.

#### Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

Sec. 3203. Sense of the House of Representatives.

#### Subtitle D—Revenue Offsets

Sec. 3301. Clarification of definition of specified liability loss.

Sec. 3302. Property subject to a liability treated in same manner as assumption of liability.

Sec. 3303. Limitation on required accrual of amounts received for performance of certain personal services.

Sec. 3304. Returns relating to cancellations of indebtedness by organizations lending money.

Sec. 3305. Clarification and expansion of mathematical error assessment procedures.

Sec. 3306. Inclusion of rotavirus gastroenteritis as a taxable vaccine.

### TITLE IV—HEALTH CARE LAWSUIT REFORM

#### Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

- Sec. 4011. Statute of limitations.  
 Sec. 4012. Calculation and payment of damages.  
 Sec. 4013. Alternative dispute resolution.  
 Sec. 4014. Reporting on fraud and abuse enforcement activities.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

- Sec. 5001. Confidentiality of protected health information.  
 Sec. 5002. Study and report on effect of State law on health-related research.  
 Sec. 5003. Study and report on State law on protected health information.  
 Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.  
 Sec. 5005. Effective date for standards governing unique health identifiers for individuals.

1 **TITLE I—AMENDMENTS TO THE**  
 2 **EMPLOYEE RETIREMENT IN-**  
 3 **COME SECURITY ACT OF 1974**  
 4 **Subtitle A—Patient Protections**

5 **SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 6 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
 7 **STETRIC AND GYNECOLOGICAL CARE, AND**  
 8 **PEDIATRIC CARE.**

9 (a) IN GENERAL.—Subpart B of part 7 of subtitle  
 10 B of title I of the Employee Retirement Income Security  
 11 Act of 1974 is amended further by adding at the end the  
 12 following new section:

13 **“SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 14 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
 15 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
 16 **ATRIC CARE.**

17 “(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL  
 18 ADVICE.—

1           “(1) IN GENERAL.—In the case of any health  
2       care professional acting within the lawful scope of  
3       practice in the course of carrying out a contractual  
4       employment arrangement or other direct contractual  
5       arrangement between such professional and a group  
6       health plan or a health insurance issuer offering  
7       health insurance coverage in connection with a group  
8       health plan, the plan or issuer with which such con-  
9       tractual employment arrangement or other direct  
10      contractual arrangement is maintained by the pro-  
11      fessional may not impose on such professional under  
12      such arrangement any prohibition or restriction with  
13      respect to advice, provided to a participant or bene-  
14      ficiary under the plan who is a patient, about the  
15      health status of the participant or beneficiary or the  
16      medical care or treatment for the condition or dis-  
17      ease of the participant or beneficiary, regardless of  
18      whether benefits for such care or treatment are pro-  
19      vided under the plan or health insurance coverage  
20      offered in connection with the plan.

21           “(2) HEALTH CARE PROFESSIONAL DEFINED.—  
22       For purposes of this subsection, the term ‘health  
23       care professional’ means a physician (as defined in  
24       section 1861(r) of the Social Security Act) or other  
25       health care professional if coverage for the profes-

1 sional’s services is provided under the group health  
2 plan for the services of the professional. Such term  
3 includes a podiatrist, optometrist, chiropractor, psy-  
4 chologist, dentist, physician assistant, physical or oc-  
5 cupational therapist and therapy assistant, speech-  
6 language pathologist, audiologist, registered or li-  
7 censed practical nurse (including nurse practitioner,  
8 clinical nurse specialist, certified registered nurse  
9 anesthetist, and certified nurse–midwife), licensed  
10 certified social worker, registered respiratory thera-  
11 pist, and certified respiratory therapy technician.

12 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
13 CARE.—

14 “(1) IN GENERAL.—To the extent that the  
15 group health plan (or health insurance issuer offer-  
16 ing health insurance coverage in connection with the  
17 plan) provides for any benefits consisting of emer-  
18 gency medical care (as defined in section  
19 503(b)(9)(I)), except for items or services specifi-  
20 cally excluded—

21 “(A) the plan or issuer shall provide bene-  
22 fits, without requiring preauthorization and  
23 without regard to otherwise applicable network  
24 limitations, for appropriate emergency medical  
25 screening examinations (within the capability of

1 the emergency facility, including ancillary serv-  
2 ices routinely available to the emergency facil-  
3 ity) to the extent that a prudent layperson, who  
4 possesses an average knowledge of health and  
5 medicine, would determine such examinations to  
6 be necessary in order to determine whether  
7 emergency medical care (as so defined) is re-  
8 quired; and

9 “(B) the plan or issuer shall provide bene-  
10 fits for additional emergency medical services  
11 following an emergency medical screening exam-  
12 ination (if determined necessary under subpara-  
13 graph (A)) to the extent that a prudent emer-  
14 gency medical professional would determine  
15 such additional emergency services to be nec-  
16 essary to avoid the consequences described in  
17 section 503(b)(9)(I).

18 “(2) UNIFORM COST-SHARING REQUIRED.—

19 Nothing in this subsection shall be construed as pre-  
20 venting a group health plan or issuer from imposing  
21 any form of cost-sharing applicable to any partici-  
22 pant or beneficiary (including coinsurance, copay-  
23 ments, deductibles, and any other charges) in rela-  
24 tion to benefits described in paragraph (1), if such  
25 form of cost-sharing is uniformly applied under such



1 plan, with respect to similarly situated participants  
2 and beneficiaries, to all benefits consisting of emer-  
3 gency medical care (as defined in section  
4 503(b)(9)(I)) provided to such similarly situated  
5 participants and beneficiaries under the plan.

6 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
7 LOGICAL CARE.—

8 “(1) IN GENERAL.—In any case in which a  
9 group health plan (or a health insurance issuer of-  
10 fering health insurance coverage in connection with  
11 the plan)—

12 “(A) provides benefits under the terms of  
13 the plan consisting of—

14 “(i) routine gynecological care (such  
15 as preventive women’s health examina-  
16 tions); or

17 “(ii) routine obstetric care (such as  
18 routine pregnancy-related services),  
19 provided by a participating physician who spe-  
20 cializes in such care (or provides benefits con-  
21 sisting of payment for such care); and

22 “(B) the plan requires or provides for des-  
23 ignation by a participant or beneficiary of a  
24 participating primary care provider,

1 if the primary care provider designated by such a  
2 participant or beneficiary is not such a physician,  
3 then the plan (or issuer) shall meet the requirements  
4 of paragraph (2).

5 “(2) REQUIREMENTS.—A group health plan (or  
6 a health insurance issuer offering health insurance  
7 coverage in connection with the plan) meets the re-  
8 quirements of this paragraph, in connection with  
9 benefits described in paragraph (1) consisting of  
10 care described in clause (i) or (ii) of paragraph  
11 (1)(A) (or consisting of payment therefor), if the  
12 plan (or issuer)—

13 “(A) does not require authorization or a  
14 referral by the primary care provider in order  
15 to obtain such benefits; and

16 “(B) treats the ordering of other routine  
17 care of the same type, by the participating phy-  
18 sician providing the care described in clause (i)  
19 or (ii) of paragraph (1)(A), as the authorization  
20 of the primary care provider with respect to  
21 such care.

22 “(3) CONSTRUCTION.—Nothing in paragraph  
23 (2)(B) shall waive any requirements of coverage re-  
24 lating to medical necessity or appropriateness with

1 respect to coverage of gynecological or obstetric care  
2 so ordered.

3 “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

4 “(1) IN GENERAL.—In any case in which a  
5 group health plan (or a health insurance issuer of-  
6 fering health insurance coverage in connection with  
7 the plan) provides benefits consisting of routine pe-  
8 diatric care provided by a participating physician  
9 who specializes in pediatrics (or consisting of pay-  
10 ment for such care) and the plan requires or pro-  
11 vides for designation by a participant or beneficiary  
12 of a participating primary care provider, the plan (or  
13 issuer) shall provide that such a participating physi-  
14 cian may be designated, if available, by a parent or  
15 guardian of any beneficiary under the plan is who  
16 under 18 years of age, as the primary care provider  
17 with respect to any such benefits.

18 “(2) CONSTRUCTION.—Nothing in paragraph  
19 (1) shall waive any requirements of coverage relating  
20 to medical necessity or appropriateness with respect  
21 to coverage of pediatric care.

22 “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
23 TIONS.—In the case of a plan providing benefits under two  
24 or more coverage options, the requirements of subsections

1 (c) and (d) shall apply separately with respect to each cov-  
2 erage option.”.

3 (b) CONFORMING AMENDMENT.—The table of con-  
4 tents in section 1 of such Act is amended by adding at  
5 the end of the items relating to subpart B of part 7 of  
6 subtitle B of title I of such Act the following new item:

“Sec. 713. Patient access to unrestricted medical advice, emergency medical  
care, obstetric and gynecological care, and pediatric care.”.

7 **SEC. 1002. EFFECTIVE DATE AND RELATED RULES.**

8 (a) IN GENERAL.—The amendments made by this  
9 subtitle shall apply with respect to plan years beginning  
10 on or after January 1 of the second calendar year follow-  
11 ing the date of the enactment of this Act, except that the  
12 Secretary of Labor may issue regulations before such date  
13 under such amendments. The Secretary shall first issue  
14 regulations necessary to carry out the amendments made  
15 by this section before the effective date thereof.

16 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
17 enforcement action shall be taken, pursuant to the amend-  
18 ments made by this subtitle, against a group health plan  
19 or health insurance issuer with respect to a violation of  
20 a requirement imposed by such amendments before the  
21 date of issuance of regulations issued in connection with  
22 such requirement, if the plan or issuer has sought to com-  
23 ply in good faith with such requirement.

1       (c) SPECIAL RULE FOR COLLECTIVE BARGAINING  
2 AGREEMENTS.—In the case of a group health plan main-  
3 tained pursuant to one or more collective bargaining  
4 agreements between employee representatives and one or  
5 more employers ratified before the date of the enactment  
6 of this Act, the provisions of subsections (b), (c), and (d)  
7 of section 713 of the Employee Retirement Income Secu-  
8 rity Act of 1974 (as added by this subtitle) shall not apply  
9 with respect to plan years beginning before the later of—

10           (1) the date on which the last of the collective  
11 bargaining agreements relating to the plan termi-  
12 nates (determined without regard to any extension  
13 thereof agreed to after the date of the enactment of  
14 this Act); or

15           (2) January 1, 2001.

16 For purposes of this subsection, any plan amendment  
17 made pursuant to a collective bargaining agreement relat-  
18 ing to the plan which amends the plan solely to conform  
19 to any requirement added by this subtitle shall not be  
20 treated as a termination of such collective bargaining  
21 agreement.

22       (d) ASSURING COORDINATION.—The Secretary of  
23 Labor, the Secretary of the Treasury, and the Secretary  
24 of Health and Human Services shall ensure, through the

1 execution of an interagency memorandum of understand-  
2 ing among such Secretaries, that—

3           (1) regulations, rulings, and interpretations  
4       issued by such Secretaries relating to the same mat-  
5       ter over which two or more such Secretaries have re-  
6       sponsibility under the provisions of this subtitle, sec-  
7       tion 2101, and subtitle A of title III (and the  
8       amendments made thereby) are administered so as  
9       to have the same effect at all times; and

10           (2) coordination of policies relating to enforcing  
11       the same requirements through such Secretaries in  
12       order to have a coordinated enforcement strategy  
13       that avoids duplication of enforcement efforts and  
14       assigns priorities in enforcement.

15       (e) TREATMENT OF RELIGIOUS NONMEDICAL PRO-  
16 VIDERS.—

17           (1) IN GENERAL.—Nothing in this Act (or the  
18       amendments made thereby) shall be construed to—

19                   (A) restrict or limit the right of group  
20       health plans, and of health insurance issuers of-  
21       fering health insurance coverage in connection  
22       with group health plans, to include as providers  
23       religious nonmedical providers;

24                   (B) require such plans or issuers to—

1 (i) utilize medically based eligibility  
2 standards or criteria in deciding provider  
3 status of religious nonmedical providers;

4 (ii) use medical professionals or cri-  
5 teria to decide patient access to religious  
6 nonmedical providers;

7 (iii) utilize medical professionals or  
8 criteria in making decisions in internal or  
9 external appeals from decisions denying or  
10 limiting coverage for care by religious non-  
11 medical providers; or

12 (iv) compel a participant or bene-  
13 ficiary to undergo a medical examination  
14 or test as a condition of receiving health  
15 insurance coverage for treatment by a reli-  
16 gious nonmedical provider; or

17 (C) require such plans or issuers to ex-  
18 clude religious nonmedical providers because  
19 they do not provide medical or other data other-  
20 wise required, if such data is inconsistent with  
21 the religious nonmedical treatment or nursing  
22 care provided by the provider.

23 (2) RELIGIOUS NONMEDICAL PROVIDER.—For  
24 purposes of this subsection, the term “religious non-  
25 medical provider” means a provider who provides no

1 medical care but who provides only religious non-  
 2 medical treatment or religious nonmedical nursing  
 3 care.

4 **Subtitle B—Patient Access to**  
 5 **Information**

6 **SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING**  
 7 **PLAN COVERAGE, MANAGED CARE PROCE-**  
 8 **DURES, HEALTH CARE PROVIDERS, AND**  
 9 **QUALITY OF MEDICAL CARE.**

10 (a) IN GENERAL.—Part 1 of subtitle B of title I of  
 11 the Employee Retirement Income Security Act of 1974 is  
 12 amended—

13 (1) by redesignating section 111 as section 112;  
 14 and

15 (2) by inserting after section 110 the following  
 16 new section:

17 “DISCLOSURE BY GROUP HEALTH PLANS

18 “SEC. 111. (a) DISCLOSURE REQUIREMENT.—

19 “(1) GROUP HEALTH PLANS.—The adminis-  
 20 trator of each group health plan shall take such ac-  
 21 tions as are necessary to ensure that the summary  
 22 plan description of the plan required under section  
 23 102 (or each summary plan description in any case  
 24 in which different summary plan descriptions are ap-  
 25 propriate under part 1 for different options of cov-  
 26 erage) contains, among any information otherwise



1 required under this part, the information required  
 2 under subsections (b), (c), (d), and (e)(2)(A).

3 “(2) HEALTH INSURANCE ISSUERS.—Each  
 4 health insurance issuer offering health insurance  
 5 coverage in connection with a group health plan  
 6 shall provide the administrator on a timely basis  
 7 with the information necessary to enable the admin-  
 8 istrator to comply with the requirements of para-  
 9 graph (1). To the extent that any such issuer pro-  
 10 vides on a timely basis to plan participants and  
 11 beneficiaries information otherwise required under  
 12 this part to be included in the summary plan de-  
 13 scription, the requirements of sections 101(a)(1) and  
 14 104(b) shall be deemed satisfied in the case of such  
 15 plan with respect to such information.

16 “(b) PLAN BENEFITS.—The information required  
 17 under subsection (a) includes the following:

18 “(1) COVERED ITEMS AND SERVICES.—

19 “(A) CATEGORIZATION OF INCLUDED BEN-  
 20 EFITS.—A description of covered benefits, cat-  
 21 egorized by—

22 “(i) types of items and services (in-  
 23 cluding any special disease management  
 24 program); and

1 “(ii) types of health care professionals  
2 providing such items and services.

3 “(B) EMERGENCY MEDICAL CARE.—A de-  
4 scription of the extent to which the plan covers  
5 emergency medical care (including the extent to  
6 which the plan provides for access to urgent  
7 care centers), and any definitions provided  
8 under the plan for the relevant plan terminol-  
9 ogy referring to such care.

10 “(C) PREVENTATIVE SERVICES.—A de-  
11 scription of the extent to which the plan pro-  
12 vides benefits for preventative services.

13 “(D) DRUG FORMULARIES.—A description  
14 of the extent to which covered benefits are de-  
15 termined by the use or application of a drug  
16 formulary and a summary of the process for de-  
17 termining what is included in such formulary.

18 “(E) COBRA CONTINUATION COV-  
19 ERAGE.—A description of the benefits available  
20 under the plan pursuant to part 6.

21 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
22 TIONS ON COVERED BENEFITS.—

23 “(A) CATEGORIZATION OF EXCLUDED  
24 BENEFITS.—A description of benefits specifi-

1 cally excluded from coverage, categorized by  
2 types of items and services.

3 “(B) UTILIZATION REVIEW AND  
4 PREAUTHORIZATION REQUIREMENTS.—Whether  
5 coverage for medical care is limited or excluded  
6 on the basis of utilization review or  
7 preauthorization requirements.

8 “(C) LIFETIME, ANNUAL, OR OTHER PE-  
9 RIOD LIMITATIONS.—A description of the cir-  
10 cumstances under which, and the extent to  
11 which, coverage is subject to lifetime, annual, or  
12 other period limitations, categorized by types of  
13 benefits.

14 “(D) CUSTODIAL CARE.—A description of  
15 the circumstances under which, and the extent  
16 to which, the coverage of benefits for custodial  
17 care is limited or excluded, and a statement of  
18 the definition used by the plan for custodial  
19 care.

20 “(E) EXPERIMENTAL TREATMENTS.—  
21 Whether coverage for any medical care is lim-  
22 ited or excluded because it constitutes experi-  
23 mental treatment or technology, and any defini-  
24 tions provided under the plan for the relevant

1 plan terminology referring to such limited or  
2 excluded care.

3 “(F) MEDICAL APPROPRIATENESS OR NE-  
4 CESSITY.—Whether coverage for medical care  
5 may be limited or excluded by reason of a fail-  
6 ure to meet the plan’s requirements for medical  
7 appropriateness or necessity, and any defini-  
8 tions provided under the plan for the relevant  
9 plan terminology referring to such limited or  
10 excluded care.

11 “(G) SECOND OR SUBSEQUENT OPIN-  
12 IONS.—A description of the circumstances  
13 under which, and the extent to which, coverage  
14 for second or subsequent opinions is limited or  
15 excluded.

16 “(H) SPECIALTY CARE.—A description of  
17 the circumstances under which, and the extent  
18 to which, coverage of benefits for specialty care  
19 is conditioned on referral from a primary care  
20 provider.

21 “(I) CONTINUITY OF CARE.—A description  
22 of the circumstances under which, and the ex-  
23 tent to which, coverage of items and services  
24 provided by any health care professional is lim-  
25 ited or excluded by reason of the departure by

1 the professional from any defined set of provid-  
2 ers.

3 “(J) RESTRICTIONS ON COVERAGE OF  
4 EMERGENCY SERVICES.—A description of the  
5 circumstances under which, and the extent to  
6 which, the plan, in covering emergency medical  
7 care furnished to a participant or beneficiary of  
8 the plan imposes any financial responsibility de-  
9 scribed in subsection (c) on participants or  
10 beneficiaries or limits or conditions benefits for  
11 such care subject to any other term or condition  
12 of such plan.

13 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
14 ITIES.—The information required under subsection (a) in-  
15 cludes an explanation of—

16 “(1) a participant’s financial responsibility for  
17 payment of premiums, coinsurance, copayments,  
18 deductibles, and any other charges; and

19 “(2) the circumstances under which, and the  
20 extent to which, the participant’s financial respon-  
21 sibility described in paragraph (1) may vary, includ-  
22 ing any distinctions based on whether a health care  
23 provider from whom covered benefits are obtained is  
24 included in a defined set of providers.

1       “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
 2 formation required under subsection (a) includes a de-  
 3 scription of the processes adopted by the plan pursuant  
 4 to section 503(b), including—

5               “(1) descriptions thereof relating specifically  
 6 to—

7                       “(A) coverage decisions;

8                       “(B) internal review of coverage decisions;

9                       and

10                      “(C) any external review of coverage deci-  
 11 sions; and

12                      “(2) the procedures and time frames applicable  
 13 to each step of the processes referred to in subpara-  
 14 graphs (A), (B), and (C) of paragraph (1).

15       “(e) INFORMATION AVAILABLE ON REQUEST.—

16               “(1) ACCESS TO PLAN BENEFIT INFORMATION  
 17 IN ELECTRONIC FORM.—

18                      “(A) IN GENERAL.—In addition to the in-  
 19 formation required to be provided under section  
 20 104(b)(4), a group health plan (and a health  
 21 insurance issuer offering health insurance cov-  
 22 erage in connection with a group health plan)  
 23 shall, upon written request (made not more fre-  
 24 quently than annually), make available to par-  
 25 ticipants and beneficiaries, in a generally recog-

nized electronic format, the following information:

“(i) the latest summary plan description, including the latest summary of material modifications; and

“(ii) the actual plan provisions setting forth the benefits available under the plan to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

“(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

“(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

1           “(A) INCLUSION IN SUMMARY PLAN DE-  
2           SCRIPTION OF SUMMARY OF ADDITIONAL IN-  
3           FORMATION.—The information required under  
4           subsection (a) includes a summary description  
5           of the types of information required by this  
6           subsection to be made available to participants  
7           and beneficiaries on request.

8           “(B) INFORMATION REQUIRED FROM  
9           PLANS AND ISSUERS ON REQUEST.—In addition  
10          to information required to be included in sum-  
11          mary plan descriptions under this subsection, a  
12          group health plan (and a health insurance  
13          issuer offering health insurance coverage in  
14          connection with a group health plan) shall pro-  
15          vide the following information to a participant  
16          or beneficiary on request:

17               “(i) NETWORK CHARACTERISTICS.—If  
18               the plan (or issuer) utilizes a defined set of  
19               providers under contract with the plan (or  
20               issuer), a detailed list of the names of such  
21               providers and their geographic location, set  
22               forth separately with respect to primary  
23               care providers and with respect to special-  
24               ists.



1                   “(ii) CARE MANAGEMENT INFORMA-  
2                   TION.—A description of the circumstances  
3                   under which, and the extent to which, the  
4                   plan has special disease management pro-  
5                   grams or programs for persons with dis-  
6                   abilities, indicating whether these pro-  
7                   grams are voluntary or mandatory and  
8                   whether a significant benefit differential  
9                   results from participation in such pro-  
10                  grams.

11                  “(iii) INCLUSION OF DRUGS AND  
12                  BIOLOGICALS IN FORMULARIES.—A state-  
13                  ment of whether a specific drug or biologi-  
14                  cal is included in a formulary used to de-  
15                  termine benefits under the plan and a de-  
16                  scription of the procedures for considering  
17                  requests for any patient-specific waivers.

18                  “(iv) PROCEDURES FOR DETERMINING  
19                  EXCLUSIONS BASED ON MEDICAL NECES-  
20                  SITY OR EXPERIMENTAL TREATMENTS.—  
21                  Upon receipt by the participant or bene-  
22                  ficiary of any notification of an adverse  
23                  coverage decision based on a determination  
24                  relating to medical necessity or an experi-  
25                  mental treatment or technology, a descrip-

tion of the procedures and medically-based criteria used in such decision.

“(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

“(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

“(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health in-

1 insurance coverage in connection with the  
2 plan, relating to enrollee satisfaction.

3 “(viii) QUALITY PERFORMANCE MEAS-  
4 URES.—The latest information (if any)  
5 maintained by the plan, or by any health  
6 insurance issuer offering health insurance  
7 coverage in connection with the plan, relat-  
8 ing to quality of performance of the deliv-  
9 ery of medical care with respect to cov-  
10 erage options offered under the plan and  
11 of health care professionals and facilities  
12 providing medical care under the plan.

13 “(ix) INFORMATION RELATING TO EX-  
14 TERNAL REVIEWS.—The number of exter-  
15 nal reviews under section 503(b)(4) that  
16 have been completed during the prior plan  
17 year and the number of such reviews in  
18 which the recommendation reported under  
19 section 503(b)(4)(C)(iii) includes a rec-  
20 ommendation for modification or reversal  
21 of an internal review decision under the  
22 plan.

23 “(C) INFORMATION REQUIRED FROM  
24 HEALTH CARE PROFESSIONALS ON REQUEST.—  
25 Any health care professional treating a partici-

1           pant or beneficiary under a group health plan  
2           shall provide to the participant or beneficiary,  
3           on request, a description of his or her profes-  
4           sional qualifications (including board certifi-  
5           cation status, licensing status, and accreditation  
6           status, if any), privileges, and experience and a  
7           general description by category (including sal-  
8           ary, fee-for-service, capitation, and such other  
9           categories as may be specified in regulations of  
10          the Secretary) of the applicable method by  
11          which such professional is compensated in con-  
12          nection with the provision of such medical care.

13                 “(D)   INFORMATION   REQUIRED   FROM  
14          HEALTH CARE FACILITIES ON REQUEST.—Any  
15          health care facility from which a participant or  
16          beneficiary has sought treatment under a group  
17          health plan shall provide to the participant or  
18          beneficiary, on request, a description of the fa-  
19          cility’s corporate form or other organizational  
20          form and all forms of licensing and accredita-  
21          tion status (if any) assigned to the facility by  
22          standard-setting organizations.

23                 “(f) ACCESS TO INFORMATION RELEVANT TO THE  
24          COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
25          BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to

1 information otherwise required to be made available under  
2 this section, a group health plan (and a health insurance  
3 issuer offering health insurance coverage in connection  
4 with a group health plan) shall, upon written request  
5 (made not more frequently than annually), make available  
6 to a participant (and an employee who, under the terms  
7 of the plan, is eligible for coverage but not enrolled) in  
8 connection with a period of enrollment the summary plan  
9 description for any coverage option under the plan under  
10 which the participant is eligible to enroll and any informa-  
11 tion described in clauses (i), (ii), (iii), (vi), (vii), and (viii)  
12 of subsection (e)(2)(B).

13 “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
14 FORMULARIES.—Not later than 30 days before the effec-  
15 tive of date of any exclusion of a specific drug or biological  
16 from any drug formulary under the plan that is used in  
17 the treatment of a chronic illness or disease, the plan shall  
18 take such actions as are necessary to reasonably ensure  
19 that plan participants are informed of such exclusion. The  
20 requirements of this subsection may be satisfied—

21 “(1) by inclusion of information in publications  
22 broadly distributed by plan sponsors, employers, or  
23 employee organizations;

24 “(2) by electronic means of communication (in-  
25 cluding the Internet or proprietary computer net-

1 works in a format which is readily accessible to par-  
2 ticipants);

3 “(3) by timely informing participants who,  
4 under an ongoing program maintained under the  
5 plan, have submitted their names for such notifica-  
6 tion; or

7 “(4) by any other reasonable means of timely  
8 informing plan participants.

9 “(h) DEFINITIONS.—For purposes of this section—

10 “(1) GROUP HEALTH PLAN.—The term ‘group  
11 health plan’ has the meaning provided such term  
12 under section 503(b)(6).

13 “(2) MEDICAL CARE.—The term ‘medical care’  
14 has the meaning provided such term under section  
15 733(a)(2).

16 “(3) HEALTH INSURANCE COVERAGE.—The  
17 term ‘health insurance coverage’ has the meaning  
18 provided such term under section 733(b)(1).

19 “(4) HEALTH INSURANCE ISSUER.—The term  
20 ‘health insurance issuer’ has the meaning provided  
21 such term under section 733(b)(2).”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) Section 102(b) of such Act (29 U.S.C.  
24 1022(b)) is amended—

1 (A) by striking “section 733(a)(1)” each  
 2 place it appears and inserting “section  
 3 503(b)(6)”;

4 (B) by inserting before the period at the  
 5 end the following: “; and, in the case of a group  
 6 health plan (as defined in section 111(h)(1)),  
 7 the information required to be included under  
 8 section 111(a)”.

9 (2) The table of contents in section 1 of such  
 10 Act is amended by striking the item relating to sec-  
 11 tion 111 and inserting the following new items:

“Sec. 111. Disclosure by group health plans.

“Sec. 112. Repeal and effective date.”.

12 **SEC. 1102. EFFECTIVE DATE AND RELATED RULES.**

13 (a) IN GENERAL.—The amendments made by this  
 14 subtitle shall apply with respect to plan years beginning  
 15 on or after January 1 of the second calendar year follow-  
 16 ing the date of the enactment of this Act. The Secretary  
 17 shall first issue all regulations necessary to carry out the  
 18 amendments made by this subtitle before such date.

19 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
 20 enforcement action shall be taken, pursuant to the amend-  
 21 ments made by this subtitle, against a group health plan  
 22 or health insurance issuer with respect to a violation of  
 23 a requirement imposed by such amendments before the  
 24 date of issuance of final regulations issued in connection

1 with such requirement, if the plan or issuer has sought  
2 to comply in good faith with such requirement.

3 (c) ASSURING COORDINATION.—The Secretary of  
4 Labor, the Secretary of Health and Human Services, and  
5 the Secretary of the Treasury shall ensure, through the  
6 execution of an interagency memorandum of understand-  
7 ing among such Secretaries, that—

8 (1) regulations, rulings, and interpretations  
9 issued by such Secretaries relating to the same mat-  
10 ter over which two or more such Secretaries have re-  
11 sponsibility under the provisions of this subtitle, sub-  
12 title B of title II, and subtitle B of title III (and the  
13 amendments made thereby) are administered so as  
14 to have the same effect at all times; and

15 (2) coordination of policies relating to enforcing  
16 the same requirements through such Secretaries in  
17 order to have a coordinated enforcement strategy  
18 that avoids duplication of enforcement efforts and  
19 assigns priorities in enforcement.



1 **Subtitle C—New Procedures and**  
2 **Access to Courts for Grievances**  
3 **Arising Under Group Health**  
4 **Plans**

5 **SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.**

6 (a) IN GENERAL.—Section 503 of the Employee Re-  
7 tirement Income Security Act of 1974 (29 U.S.C. 1133)  
8 is amended—

9 (1) by inserting “(a) IN GENERAL.—” after  
10 “SEC. 503.”;

11 (2) by inserting “(other than a group health  
12 plan)” after “employee benefit plan”; and

13 (3) by adding at the end the following new sub-  
14 section:

15 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

16 “(1) COVERAGE DETERMINATIONS.—Every  
17 group health plan shall—

18 “(A) provide adequate notice in writing in  
19 accordance with this subsection to any partici-  
20 pant or beneficiary of any adverse coverage de-  
21 cision with respect to benefits of such partici-  
22 pant or beneficiary under the plan, setting forth  
23 the specific reasons for such coverage decision  
24 and any rights of review provided under the

1 plan, written in a manner calculated to be un-  
2 derstood by the participant;

3 “(B) provide such notice in writing also to  
4 any treating medical care provider of such par-  
5 ticipant or beneficiary, if such provider has  
6 claimed reimbursement for any item or service  
7 involved in such coverage decision, or if a claim  
8 submitted by the provider initiated the proceed-  
9 ings leading to such decision;

10 “(C) afford a reasonable opportunity to  
11 any participant or beneficiary who is in receipt  
12 of the notice of such adverse coverage decision,  
13 and who files a written request for review of the  
14 initial coverage decision within 180 days after  
15 receipt of the notice of the initial decision, for  
16 a full and fair de novo review of the decision by  
17 an appropriate named fiduciary who did not  
18 make the initial decision; and

19 “(D) meet the additional requirements of  
20 this subsection.

21 “(2) TIME LIMITS FOR MAKING INITIAL COV-  
22 ERAGE DECISIONS FOR BENEFITS AND COMPLETING  
23 INTERNAL APPEALS.—

24 “(A) TIME LIMITS FOR DECIDING RE-  
25 QUESTS FOR BENEFIT PAYMENTS, REQUESTS

1           FOR ADVANCE DETERMINATION OF COVERAGE,  
2           AND REQUESTS FOR REQUIRED DETERMINA-  
3           TION OF MEDICAL NECESSITY.—Except as pro-  
4           vided in subparagraph (B)—

5                   “(i) INITIAL DECISIONS.—If a request  
6                   for benefit payments, a request for advance  
7                   determination of coverage, or a request for  
8                   required determination of medical necessity  
9                   is submitted to a group health plan in such  
10                  reasonable form as may be required under  
11                  the plan, the plan shall issue in writing an  
12                  initial coverage decision on the request be-  
13                  fore the end of the initial decision period  
14                  under paragraph (9)(J) following the filing  
15                  completion date. Failure to issue a cov-  
16                  erage decision on such a request before the  
17                  end of the period required under this  
18                  clause shall be treated as an adverse cov-  
19                  erage decision for purposes of internal re-  
20                  view under clause (ii).

21                  “(ii) INTERNAL REVIEWS OF INITIAL  
22                  DENIALS.—Upon the written request of a  
23                  participant or beneficiary for review of an  
24                  initial adverse coverage decision under  
25                  clause (i), a review by an appropriate

1            named fiduciary (subject to paragraph (3))  
2            of the initial coverage decision shall be  
3            completed, including issuance by the plan  
4            of a written decision affirming, reversing,  
5            or modifying the initial coverage decision,  
6            setting forth the grounds for such decision,  
7            before the end of the internal review period  
8            following the review filing date. Such deci-  
9            sion shall be treated as the final decision  
10          of the plan, subject to any applicable re-  
11          consideration under paragraph (4). Failure  
12          to issue before the end of such period such  
13          a written decision requested under this  
14          clause shall be treated as a final decision  
15          affirming the initial coverage decision, sub-  
16          ject to any applicable reconsideration  
17          under paragraph (4).

18            “(B) TIME LIMITS FOR MAKING COVERAGE  
19            DECISIONS RELATING TO URGENT AND EMER-  
20            GENCY MEDICAL CARE AND FOR COMPLETING  
21            INTERNAL APPEALS.—

22            “(i) INITIAL DECISIONS.—A group  
23            health plan shall issue in writing an initial  
24            coverage decision on any request for expe-  
25            dited advance determination of coverage or

1 for expedited required determination of  
2 medical necessity submitted, in such rea-  
3 sonable form as may be required under the  
4 plan—

5 “(I) before the end of the urgent  
6 decision period under paragraph  
7 (9)(L), in cases involving urgent med-  
8 ical care but not involving emergency  
9 medical care; or

10 “(II) before the end of the emer-  
11 gency decision period under para-  
12 graph (9)(M), in cases involving emer-  
13 gency medical care,  
14 following the filing completion date. Fail-  
15 ure to approve or deny such a request be-  
16 fore the end of the applicable decision pe-  
17 riod shall be treated as a denial of the re-  
18 quest for purposes of internal review under  
19 clause (ii).

20 “(ii) INTERNAL REVIEWS OF INITIAL  
21 DENIALS.—Upon the written request of a  
22 participant or beneficiary for review of an  
23 initial adverse coverage decision under  
24 clause (i), a review by an appropriate  
25 named fiduciary (subject to paragraph (3))

1 of the initial coverage decision shall be  
2 completed, including issuance by the plan  
3 of a written decision affirming, reversing,  
4 or modifying the initial coverage decision,  
5 setting forth the grounds for the deci-  
6 sion—

7 “(I) before the end of the urgent  
8 decision period under paragraph  
9 (9)(L), in cases involving urgent med-  
10 ical care but not involving emergency  
11 medical care; or

12 “(II) before the end of the emer-  
13 gency decision period under para-  
14 graph (9)(M), in cases involving emer-  
15 gency medical care,

16 following the review filing date. Such deci-  
17 sion shall be treated as the final decision  
18 of the plan, subject to any applicable re-  
19 consideration under paragraph (4). Failure  
20 to issue before the end of the applicable  
21 decision period such a written decision re-  
22 quested under this clause shall be treated  
23 as a final decision affirming the initial cov-  
24 erage decision, subject to any applicable re-  
25 consideration under paragraph (4).

1           “(3) PHYSICIANS MUST REVIEW INITIAL COV-  
2           ERAGE DECISIONS INVOLVING MEDICAL APPRO-  
3           PRIATENESS OR NECESSITY OR EXPERIMENTAL  
4           TREATMENT.—If an initial coverage decision under  
5           paragraph (2)(A)(i) or (2)(B)(i) is based on a deter-  
6           mination that provision of a particular item or serv-  
7           ice is excluded from coverage under the terms of the  
8           plan because the provision of such item or service  
9           does not meet the plan’s requirements for medical  
10          appropriateness or necessity or would constitute ex-  
11          perimental treatment or technology, the review  
12          under paragraph (2)(A)(ii) or (2)(B)(ii), to the ex-  
13          tent that it relates to medical appropriateness or ne-  
14          cessity or to experimental treatment or technology,  
15          shall be conducted by a physician who is selected to  
16          serve as an appropriate named fiduciary under the  
17          plan and who did not make the initial denial.

18           “(4) ELECTIVE EXTERNAL REVIEW BY INDE-  
19           PENDENT MEDICAL EXPERT AND RECONSIDERATION  
20           OF INITIAL REVIEW DECISION.—

21           “(A) IN GENERAL.—The requirements of  
22           subparagraphs (B), (C) and (D) shall apply—

23                   “(i) in the case of any failure to time-  
24                   ly issue a coverage decision upon internal  
25                   review which is deemed to be an adverse

1 coverage decision under paragraph  
2 (2)(A)(ii) or (2)(B)(ii) (thereby failing to  
3 constitute a coverage decision for which  
4 specific reasons have been set forth as re-  
5 quired under paragraph (1)(A)); and

6 “(ii) in the case of any adverse cov-  
7 erage decision which is not reversed upon  
8 a review conducted pursuant to paragraph  
9 (1)(C) (including any review pursuant to  
10 paragraph (2)(A)(ii) or (2)(B)(ii)), if such  
11 coverage decision is based on a determina-  
12 tion that provision of a particular item or  
13 service is excluded from coverage under the  
14 terms of the plan because the provision of  
15 such item or service—

16 “(I) does not meet the plan’s re-  
17 quirements for medical appropriate-  
18 ness or necessity; or

19 “(II) would constitute experi-  
20 mental treatment or technology.

21 “(B) LIMITS ON ALLOWABLE ADVANCE  
22 PAYMENTS.—The review under this paragraph  
23 in connection with an adverse coverage decision  
24 shall be available subject to any requirement of  
25 the plan (unless waived by the plan for financial



1 or other reasons) for payment in advance to the  
2 plan by the participant or beneficiary seeking  
3 review of an amount not to exceed the greater  
4 of—

5 “(i) the lesser of \$100 or 10 percent  
6 of the cost of the medical care involved in  
7 the decision; or

8 “(ii) \$25,  
9 with each such dollar amount subject to com-  
10 pounded annual adjustments in the same man-  
11 ner and to the same extent as apply under sec-  
12 tion 215(i) of the Social Security Act, except  
13 that, for any calendar year, such amount as so  
14 adjusted shall be deemed, solely for such cal-  
15 endar year, to be equal to such amount rounded  
16 to the nearest \$10. No such payment may be  
17 required in the case of any participant or bene-  
18 ficiary whose enrollment under the plan is paid  
19 for, in whole or in part, under a State plan  
20 under title XIX or XXI of the Social Security  
21 Act. Any such advance payment shall be subject  
22 to reimbursement if the recommendation of the  
23 independent medical expert or experts under  
24 subparagraph (C)(iii) is to reverse or modify  
25 the coverage decision.

1           “(C) RECONSIDERATION OF INITIAL RE-  
2           VIEW DECISION.—In any case in which a partic-  
3           ipant or beneficiary who has received an ad-  
4           verse decision of the plan upon initial review of  
5           the coverage decision and who has not com-  
6           menced review of the initial coverage decision  
7           under section 502 makes a request in writing,  
8           within 30 days after the date of such review de-  
9           cision, for reconsideration of such review deci-  
10          sion, the terms of the plan shall provide for a  
11          procedure for such reconsideration under  
12          which—

13               “(i) one or more independent medical  
14               experts will be selected in accordance with  
15               subparagraph (E) to review the coverage  
16               decision described in subparagraph (A) to  
17               determine whether such decision was in ac-  
18               cordance with the terms of the plan and  
19               this title;

20               “(ii) the record for review (including a  
21               specification of the terms of the plan and  
22               other criteria serving as the basis for the  
23               initial review decision) will be presented to  
24               such expert or experts and maintained in

1 a manner which will ensure confidentiality  
2 of such record;

3 “(iii) such expert or experts will re-  
4 port in writing to the plan their rec-  
5 ommendation, based on the determination  
6 made under clause (i), as to whether such  
7 coverage decision should be affirmed, modi-  
8 fied, or reversed, setting forth the grounds  
9 (including the clinical basis) for the rec-  
10 ommendation; and

11 “(iv) a physician who did not make  
12 the initial review decision will reconsider  
13 the initial review decision to determine  
14 whether such decision was in accordance  
15 with the terms of the plan and this title  
16 and will issue a written decision affirming,  
17 modifying, or reversing the initial review  
18 decision, taking into account any rec-  
19 ommendations reported to the plan pursu-  
20 ant to clause (iii), and setting forth the  
21 grounds for the decision.

22 “(D) TIME LIMITS FOR RECONSIDER-  
23 ATION.—Any review under this paragraph shall  
24 be completed before the end of the reconsider-  
25 ation period (as defined in paragraph (9)(O))

1 following the review filing date in connection  
2 with such review. The decision under this para-  
3 graph affirming, reversing, or modifying the ini-  
4 tial review decision of the plan shall be the final  
5 decision of the plan. Failure to issue a written  
6 decision before the end of the reconsideration  
7 period in any reconsideration requested under  
8 this paragraph shall be treated as a final deci-  
9 sion affirming the initial review decision of the  
10 plan.

11 “(E) INDEPENDENT MEDICAL EXPERTS.—

12 “(i) IN GENERAL.—For purposes of  
13 this paragraph, the term ‘independent  
14 medical expert’ means, in connection with  
15 any coverage decision by a group health  
16 plan, a professional—

17 “(I) who is a physician or, if ap-  
18 propriate, another medical profes-  
19 sional;

20 “(II) who has appropriate cre-  
21 dentials and has attained recognized  
22 expertise in the applicable medical  
23 field;

1 “(III) who was not involved in  
2 the initial decision or any earlier re-  
3 view thereof; and

4 “(IV) who is selected in accord-  
5 ance with clause (ii) and meets the re-  
6 quirements of clause (iii).

7 “(ii) SELECTION OF MEDICAL EX-  
8 PERTS.—An independent medical expert is  
9 selected in accordance with this clause if—

10 “(I) the expert is selected by an  
11 intermediary which itself meets the re-  
12 quirements of clause (iii), by means of  
13 a method which ensures that the iden-  
14 tity of the expert is not disclosed to  
15 the plan, any health insurance issuer  
16 offering health insurance coverage to  
17 the aggrieved participant or bene-  
18 ficiary in connection with the plan,  
19 and the aggrieved participant or bene-  
20 ficiary under the plan, and the identi-  
21 ties of the plan, the issuer, and the  
22 aggrieved participant or beneficiary  
23 are not disclosed to the expert;

24 “(II) the expert is selected, by an  
25 appropriately credentialed panel of

1 physicians meeting the requirements  
2 of clause (iii) established by a fully  
3 accredited teaching hospital meeting  
4 such requirements;

5 “(III) the expert is selected by an  
6 organization described in section  
7 1152(1)(A) of the Social Security Act  
8 which meets the requirements of  
9 clause (iii);

10 “(IV) the expert is selected by an  
11 external review organization which  
12 meets the requirements of clause (iii)  
13 and is accredited by a private stand-  
14 ard-setting organization meeting such  
15 requirements and recognized as such  
16 by the Secretary; or

17 “(V) the expert is selected, by an  
18 intermediary or otherwise, in a man-  
19 ner that is, under regulations issued  
20 pursuant to negotiated rulemaking,  
21 sufficient to ensure the expert’s inde-  
22 pendence,

23 and the method of selection is devised to  
24 reasonably ensure that the expert selected

1 meets the independence requirements of  
2 clause (iii).

3 “(iii) INDEPENDENCE REQUIRE-  
4 MENTS.—An independent medical expert  
5 or another entity described in clause (ii)  
6 meets the independence requirements of  
7 this clause if—

8 “(I) the expert or entity is not  
9 affiliated with any related party;

10 “(II) any compensation received  
11 by such expert or entity in connection  
12 with the external review is reasonable  
13 and not contingent on any decision  
14 rendered by the expert or entity;

15 “(III) under the terms of the  
16 plan and any health insurance cov-  
17 erage offered in connection with the  
18 plan, the plan and the issuer (if any)  
19 have no recourse against the expert or  
20 entity in connection with the external  
21 review; and

22 “(IV) the expert or entity does  
23 not otherwise have a conflict of inter-  
24 est with a related party as determined

1 under any regulations which the Sec-  
2 retary may prescribe.

3 “(iv) RELATED PARTY.—For purposes  
4 of clause (ii)(I), the term ‘related party’  
5 means—

6 “(I) the plan or any health insur-  
7 ance issuer offering health insurance  
8 coverage in connection with the plan  
9 (or any officer, director, or manage-  
10 ment employee of such plan or issuer);

11 “(II) the physician or other medi-  
12 cal care provider that provided the  
13 medical care involved in the coverage  
14 decision;

15 “(III) the institution at which  
16 the medical care involved in the cov-  
17 erage decision is provided;

18 “(IV) the manufacturer of any  
19 drug or other item that was included  
20 in the medical care involved in the  
21 coverage decision; or

22 “(V) any other party determined  
23 under any regulations which the Sec-  
24 retary may prescribe to have a sub-



1                   stantial interest in the coverage deci-  
2                   sion .

3                   “(v) AFFILIATED.—For purposes of  
4                   clause (iii)(I), the term ‘affiliated’ means,  
5                   in connection with any entity, having a fa-  
6                   milial, financial, or professional relation-  
7                   ship with, or interest in, such entity.

8                   “(F) INAPPLICABILITY WITH RESPECT TO  
9                   ITEMS AND SERVICES SPECIFICALLY EXCLUDED  
10                  FROM COVERAGE.—An adverse coverage deci-  
11                  sion based on a determination that an item or  
12                  service is excluded from coverage under the  
13                  terms of the plan shall not be subject to review  
14                  under this paragraph, unless such determina-  
15                  tion is found in such decision to be based solely  
16                  on the fact that the item or service—

17                  “(i) does not meet the plan’s require-  
18                  ments for medical appropriateness or ne-  
19                  cessity; or

20                  “(ii) would constitute experimental  
21                  treatment or technology (as defined under  
22                  the plan).

23                  “(5) PERMITTED ALTERNATIVES TO REQUIRED  
24                  INTERNAL REVIEW.—

1           “(A) IN GENERAL.—A group health plan  
2 shall not be treated as failing to meet the re-  
3 quirements under paragraphs (2)(A)(ii) and  
4 (2)(B)(ii) relating to review of initial coverage  
5 decisions for benefits, if—

6           “(i) in lieu of the procedures relating  
7 to review under paragraphs (2)(A)(ii) and  
8 (2)(B)(ii) and in accordance with such reg-  
9 ulations (if any) as may be prescribed by  
10 the Secretary—

11           “(I) the aggrieved participant or  
12 beneficiary elects in the request for  
13 the review an alternative dispute reso-  
14 lution procedure which is available  
15 under the plan with respect to simi-  
16 larly situated participants and bene-  
17 ficiaries; or

18           “(II) in the case of any such plan  
19 or portion thereof which is established  
20 and maintained pursuant to a bona  
21 fide collective bargaining agreement,  
22 the plan provides for a procedure by  
23 which such disputes are resolved by  
24 means of any alternative dispute reso-  
25 lution procedure;

1 “(ii) the time limits not exceeding the  
2 time limits otherwise applicable under  
3 paragraphs (2)(A)(ii) and (2)(B)(ii) are in-  
4 corporated in such alternative dispute reso-  
5 lution procedure;

6 “(iii) any applicable requirement for  
7 review by a physician under paragraph (3),  
8 unless waived by the participant or bene-  
9 ficiary (in a manner consistent with such  
10 regulations as the Secretary may prescribe  
11 to ensure equitable procedures), is incor-  
12 porated in such alternative dispute resolu-  
13 tion procedure; and

14 “(iv) the plan meets the additional re-  
15 quirements of subparagraph (B).

16 In any case in which a procedure described in  
17 subclause (I) or (II) of clause (i) is utilized and  
18 an alternative dispute resolution procedure is  
19 voluntarily elected by the aggrieved participant  
20 or beneficiary, the plan may require or allow (in  
21 a manner consistent with such regulations as  
22 the Secretary may prescribe to ensure equitable  
23 procedures) the aggrieved participant or bene-  
24 ficiary to waive review of the coverage decision  
25 under paragraph (3), to waive further review of

1 the coverage decision under paragraph (4) or  
2 section 502, and to elect an alternative means  
3 of external review (other than review under  
4 paragraph (4)).

5 “(B) ADDITIONAL REQUIREMENTS.—The  
6 requirements of this subparagraph are met if  
7 the means of resolution of dispute allow for  
8 adequate presentation by the aggrieved partici-  
9 pant or beneficiary of scientific and medical evi-  
10 dence supporting the position of such partici-  
11 pant or beneficiary.

12 “(6) PERMITTED ALTERNATIVES TO REQUIRED  
13 EXTERNAL REVIEW.—A group health plan shall not  
14 be treated as failing to meet the requirements of this  
15 subsection in connection with review of coverage de-  
16 cisions under paragraph (4) if the aggrieved partici-  
17 pant or beneficiary elects to utilize a procedure in  
18 connection with such review which is made generally  
19 available under the plan (in a manner consistent  
20 with such regulations as the Secretary may prescribe  
21 to ensure equitable procedures) under which—

22 “(A) the plan agrees in advance of the rec-  
23 ommendations of the independent medical ex-  
24 pert or experts under paragraph (4)(C)(iii) to

1           render a final decision in accordance with such  
2           recommendations; and

3                 “(B) the participant or beneficiary waives  
4           in advance any right to review of the final deci-  
5           sion under section 502.

6                 “(7) SPECIAL RULE FOR ACCESS TO SPECIALTY  
7           CARE.— In the case of a request for advance deter-  
8           mination of coverage consisting of a request by a  
9           physician for a determination of coverage of the  
10          services of a specialist with respect to any condition,  
11          if coverage of the services of such specialist for such  
12          condition is otherwise provided under the plan, the  
13          initial coverage decision referred to in subparagraph  
14          (A)(i) or (B)(i) of paragraph (2) shall be issued  
15          within the specialty decision period. For purposes of  
16          this paragraph, the term ‘specialist’ means, with re-  
17          spect to a condition, a physician who has a high level  
18          of expertise through appropriate training and experi-  
19          ence (including, in the case of a child, appropriate  
20          pediatric expertise) to treat the condition.

21                 “(8) GROUP HEALTH PLAN DEFINED.—For  
22          purposes of this section—

23                 “(A) IN GENERAL.—The term ‘group  
24          health plan’ shall have the meaning provided in  
25          section 733(a).

1 “(B) TREATMENT OF PARTNERSHIPS.—

2 The provisions of paragraphs (1), (2), and (3)  
3 of section 732(d) shall apply.

4 “(9) OTHER DEFINITIONS.—For purposes of  
5 this subsection—

6 “(A) REQUEST FOR BENEFIT PAY-  
7 MENTS.—The term ‘request for benefit pay-  
8 ments’ means a request, for payment of benefits  
9 by a group health plan for medical care, which  
10 is made by or on behalf of a participant or ben-  
11 eficiary after such medical care has been pro-  
12 vided.

13 “(B) REQUIRED DETERMINATION OF MED-  
14 ICAL NECESSITY.—The term ‘required deter-  
15 mination of medical necessity’ means a deter-  
16 mination required under a group health plan  
17 solely that proposed medical care meets, under  
18 the facts and circumstances at the time of the  
19 determination, the plan’s requirements for med-  
20 ical appropriateness or necessity (which may be  
21 subject to exceptions under the plan for fraud  
22 or misrepresentation), irrespective of whether  
23 the proposed medical care otherwise meets  
24 other terms and conditions of coverage, but  
25 only if such determination does not constitute

1 an advance determination of coverage (as de-  
2 fined in subparagraph (C)).

3 “(C) ADVANCE DETERMINATION OF COV-  
4 ERAGE.—The term ‘advance determination of  
5 coverage’ means a determination under a group  
6 health plan that proposed medical care meets,  
7 under the facts and circumstances at the time  
8 of the determination, the plan’s terms and con-  
9 ditions of coverage (which may be subject to ex-  
10 ceptions under the plan for fraud or misrepre-  
11 sentation).

12 “(D) REQUEST FOR ADVANCE DETERMINA-  
13 TION OF COVERAGE.—The term ‘request for ad-  
14 vance determination of coverage’ means a re-  
15 quest for an advance determination of coverage  
16 of medical care which is made by or on behalf  
17 of a participant or beneficiary before such medi-  
18 cal care is provided.

19 “(E) REQUEST FOR EXPEDITED ADVANCE  
20 DETERMINATION OF COVERAGE.—The term ‘re-  
21 quest for expedited advance determination of  
22 coverage’ means a request for advance deter-  
23 mination of coverage, in any case in which the  
24 proposed medical care constitutes urgent medi-  
25 cal care or emergency medical care.

1           “(F) REQUEST FOR REQUIRED DETER-  
2 MINATION OF MEDICAL NECESSITY.—The term  
3 ‘request for required determination of medical  
4 necessity’ means a request for a required deter-  
5 mination of medical necessity for medical care  
6 which is made by or on behalf of a participant  
7 or beneficiary before the medical care is pro-  
8 vided.

9           “(G) REQUEST FOR EXPEDITED REQUIRED  
10 DETERMINATION OF MEDICAL NECESSITY.—  
11 The term ‘request for expedited required deter-  
12 mination of medical necessity’ means a request  
13 for required determination of medical necessity  
14 in any case in which the proposed medical care  
15 constitutes urgent medical care or emergency  
16 medical care.

17           “(H) URGENT MEDICAL CARE.—The term  
18 ‘urgent medical care’ means medical care in any  
19 case in which an appropriate physician has cer-  
20 tified in writing (or as otherwise provided in  
21 regulations of the Secretary) that failure to pro-  
22 vide the participant or beneficiary with such  
23 medical care within 45 days can reasonably be  
24 expected to result in either—



1 “(i) the imminent death of the partici-  
2 pant or beneficiary; or

3 “(ii) the immediate, serious, and irre-  
4 versible deterioration of the health of the  
5 participant or beneficiary which will sig-  
6 nificantly increase the likelihood of death  
7 of, or irreparable harm to, the participant  
8 or beneficiary.

9 “(I) EMERGENCY MEDICAL CARE.—The  
10 term ‘emergency medical care’ means medical  
11 care in any case in which an appropriate physi-  
12 cian has certified in writing (or as otherwise  
13 provided in regulations of the Secretary)—

14 “(i) that failure to immediately pro-  
15 vide the care to the participant or bene-  
16 ficiary could reasonably be expected to re-  
17 sult in—

18 “(I) placing the health of such  
19 participant or beneficiary (or, with re-  
20 spect to such a participant or bene-  
21 ficiary who is a pregnant woman, the  
22 health of the woman or her unborn  
23 child) in serious jeopardy;

24 “(II) serious impairment to bod-  
25 ily functions; or

1                   “(III) serious dysfunction of any  
2                   bodily organ or part; or

3                   “(ii) that immediate provision of the  
4                   care is necessary because the participant  
5                   or beneficiary has made or is at serious  
6                   risk of making an attempt to harm himself  
7                   or herself or another individual.

8                   “(J) INITIAL DECISION PERIOD.—The  
9                   term ‘initial decision period’ means a period of  
10                  30 days, or such longer period as may be pre-  
11                  scribed in regulations of the Secretary.

12                  “(K) INTERNAL REVIEW PERIOD.—The  
13                  term ‘internal review period’ means a period of  
14                  30 days, or such longer period as may be pre-  
15                  scribed in regulations of the Secretary.

16                  “(L) URGENT DECISION PERIOD.—The  
17                  term ‘urgent decision period’ means a period of  
18                  10 days, or such longer period as may be pre-  
19                  scribed in regulations of the Secretary.

20                  “(M) EMERGENCY DECISION PERIOD.—  
21                  The term ‘emergency decision period’ means a  
22                  period of 72 hours, or such longer period as  
23                  may be prescribed in regulations of the Sec-  
24                  retary.

1           “(N) SPECIALTY DECISION PERIOD.—The  
2 term ‘specialty decision period’ means a period  
3 of 72 hours, or such longer period as may be  
4 prescribed in regulations of the Secretary.

5           “(O) RECONSIDERATION PERIOD.—The  
6 term ‘reconsideration period’ means a period of  
7 25 days, or such longer period as may be pre-  
8 scribed in regulations of the Secretary, except  
9 that—

10           “(i) in the case of a decision involving  
11 urgent medical care, such term means the  
12 urgent decision period; and

13           “(ii) in the case of a decision involving  
14 emergency medical care, such term means  
15 the emergency decision period.

16           “(P) FILING COMPLETION DATE.—The  
17 term ‘filing completion date’ means, in connec-  
18 tion with a group health plan, the date as of  
19 which the plan is in receipt of all information  
20 reasonably required (in writing or in such other  
21 reasonable form as may be specified by the  
22 plan) to make an initial coverage decision.

23           “(Q) REVIEW FILING DATE.—The term  
24 ‘review filing date’ means, in connection with a  
25 group health plan, the date as of which the ap-

1           appropriate named fiduciary (or the independent  
2           medical expert or experts in the case of a review  
3           under paragraph (4)) is in receipt of all infor-  
4           mation reasonably required (in writing or in  
5           such other reasonable form as may be specified  
6           by the plan) to make a decision to affirm, mod-  
7           ify, or reverse a coverage decision.

8           “(R) MEDICAL CARE.—The term ‘medical  
9           care’ has the meaning provided such term by  
10          section 733(a)(2).

11          “(S) HEALTH INSURANCE COVERAGE.—  
12          The term ‘health insurance coverage’ has the  
13          meaning provided such term by section  
14          733(b)(1).

15          “(T) HEALTH INSURANCE ISSUER.—The  
16          term ‘health insurance issuer’ has the meaning  
17          provided such term by section 733(b)(2).

18          “(U) WRITTEN OR IN WRITING.—

19                 “(i) IN GENERAL.—A request or deci-  
20                 sion shall be deemed to be ‘written’ or ‘in  
21                 writing’ if such request or decision is pre-  
22                 sented in a generally recognized printable  
23                 or electronic format. The Secretary may by  
24                 regulation provide for presentation of in-  
25                 formation otherwise required to be in writ-

1           ten form in such other forms as may be  
2           appropriate under the circumstances.

3           “(ii) MEDICAL APPROPRIATENESS OR  
4           EXPERIMENTAL TREATMENT DETERMINA-  
5           TIONS.—For purposes of this subpara-  
6           graph, in the case of a request for advance  
7           determination of coverage, a request for  
8           expedited advance determination of cov-  
9           erage, a request for required determination  
10          of medical necessity, or a request for expe-  
11          dited required determination of medical ne-  
12          cessity, if the decision on such request is  
13          conveyed to the provider of medical care or  
14          to the participant or beneficiary by means  
15          of telephonic or other electronic commu-  
16          nications, such decision shall be treated as  
17          a written decision.”.

18       (b) CIVIL PENALTIES.—

19           (1) IN GENERAL.—Section 502(c) of such Act  
20       (29 U.S.C. 1132(c)) is amended by redesignating  
21       paragraphs (6) and (7) as paragraphs (7) and (8),  
22       respectively, and by inserting after paragraph (5)  
23       the following new paragraph:

24       “(6)(A)(i) In any case in which—

1           “(I) a benefit under a group health plan (as de-  
2       fined in section 503(b)(8)) is not timely provided to  
3       a participant or beneficiary pursuant to a final deci-  
4       sion of the plan which was not in accordance with  
5       the terms of the plan or this title; and

6           “(II) such final decision of the plan is contrary  
7       to a recommendation described in section  
8       503(b)(4)(C)(iii),

9       any person acting in the capacity of a fiduciary of such  
10      plan so as to cause such failure may, in the court’s discre-  
11      tion, be liable to the aggrieved participant or beneficiary  
12      for a civil penalty.

13       “(ii) Such civil penalty shall be in the amount of up  
14      to \$500 a day (or up to \$1,000 a day in the case of a  
15      bad faith failure) from the date on which the recommenda-  
16      tion was made to the plan until the date the failure to  
17      provide benefits is corrected, up to a total amount not to  
18      exceed \$250,000.

19       “(B) In any action commenced under subsection (a)  
20      by a participant or beneficiary with respect to a group  
21      health plan (as defined in section 503(b)(8)) in which the  
22      plaintiff alleges that a person, in the capacity of a fidu-  
23      ciary and in violation of the terms of the plan or this title,  
24      has taken an action resulting in an adverse coverage deci-  
25      sion in violation of the terms of the plan, or has failed

1 to take an action for which such person is responsible  
2 under the plan and which is necessary under the plan for  
3 a favorable coverage decision, upon finding in favor of the  
4 plaintiff, if such action was commenced after a final deci-  
5 sion of the plan upon review which included a review under  
6 section 503(b)(4) or such action was commenced under  
7 subsection (b)(4) of this section, the court shall cause to  
8 be served on the defendant an order requiring the defend-  
9 ant—

10 “(i) to cease and desist from the alleged action  
11 or failure to act; and

12 “(ii) to pay to the plaintiff a reasonable attor-  
13 ney’s fee and other reasonable costs relating to the  
14 prosecution of the action on the charges on which  
15 the plaintiff prevails.

16 The remedies provided under this subparagraph shall be  
17 in addition to remedies otherwise provided under this sec-  
18 tion.

19 “(C)(i) The Secretary may assess a civil penalty  
20 against a person acting in the capacity of a fiduciary of  
21 one or more group health plans (as defined in section  
22 503(b)(8)) for—

23 “(I) any pattern or practice of repeated adverse  
24 coverage decisions in violation of the terms of the  
25 plan or plans or this title; or

1           “(II) any pattern or practice of repeated viola-  
2           tions of the requirements of section 503 with respect  
3           to such plan or plans.

4   Such penalty shall be payable only upon proof by clear  
5   and convincing evidence of such pattern or practice.

6           “(ii) Such penalty shall be in an amount not to exceed  
7   the lesser of—

8           “(I) 5 percent of the aggregate value of benefits  
9           shown by the Secretary to have not been provided,  
10          or unlawfully delayed in violation of section 503,  
11          under such pattern or practice; or

12          “(II) \$100,000.

13          “(iii) Any person acting in the capacity of a fiduciary  
14   of a group health plan or plans who has engaged in any  
15   such pattern or practice with respect to such plans, upon  
16   the petition of the Secretary, may be removed by the court  
17   from that position, and from any other involvement, with  
18   respect to such plan or plans, and may be precluded from  
19   returning to any such position or involvement for a period  
20   determined by the court.”.

21           (2)     CONFORMING     AMENDMENT.—Section  
22     502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is  
23     amended by striking “, or (6)” and inserting “, (6),  
24     or (7)”.



1       (c) EXPEDITED COURT REVIEW.—Section 502 of  
2 such Act (29 U.S.C. 1132) is amended—

3           (1) in subsection (a)(8), by striking “or” at the  
4 end;

5           (2) in subsection (a)(9), by striking the period  
6 and inserting “; or”;

7           (3) by adding at the end of subsection (a) the  
8 following new paragraph:

9       “(10) by a participant or beneficiary for appropriate  
10 relief under subsection (b)(4).”.

11           (4) by adding at the end of subsection (b) the  
12 following new paragraph:

13       “(4) In any case in which exhaustion of administra-  
14 tive remedies in accordance with paragraph (2)(A)(ii) or  
15 (2)(B)(ii) of section 503(b) otherwise necessary for an ac-  
16 tion for relief under paragraph (1)(B) or (3) of subsection  
17 (a) has not been obtained and it is demonstrated to the  
18 court by means of certification by an appropriate physi-  
19 cian that such exhaustion is not reasonably attainable  
20 under the facts and circumstances without undue risk of  
21 irreparable harm to the health of the participant or bene-  
22 ficiary, a civil action may be brought by a participant or  
23 beneficiary to obtain appropriate equitable relief. Any de-  
24 terminations made under paragraph (2)(A)(ii) or  
25 (2)(B)(ii) of section 503(b) made while an action under

1 this paragraph is pending shall be given due consideration  
2 by the court in any such action.”.

3 (d) STANDARD OF REVIEW UNAFFECTED.—The  
4 standard of review under section 502 of the Employee Re-  
5 tirement Income Security Act of 1974 (as amended by this  
6 section) shall continue on and after the date of the enact-  
7 ment of this Act to be the standard of review which was  
8 applicable under such section as of immediately before  
9 such date.

10 (e) CONCURRENT JURISDICTION.—Section 502(e)(1)  
11 of such Act (29 U.S.C. 1132(e)(1)) is amended—

12 (1) in the first sentence, by striking “under  
13 subsection (a)(1)(B) of this section” and inserting  
14 “under subsection (a)(1)(A) for relief under sub-  
15 section (c)(6), under subsection (a)(1)(B), and  
16 under subsection (b)(4)”; and

17 (2) in the last sentence, by striking “of actions  
18 under paragraphs (1)(B) and (7) of subsection (a)  
19 of this section” and inserting “of actions under  
20 paragraph (1)(A) of subsection (a) for relief under  
21 subsection (c)(6) and of actions under paragraphs  
22 (1)(B) and (7) of subsection (a) and paragraph (4)  
23 of subsection (b)”.

1 **SEC. 1202. EFFECTIVE DATE.**

2 (a) IN GENERAL.—The amendments made by this  
3 subtitle shall apply with respect to grievances arising in  
4 plan years beginning on or after January 1 of the second  
5 calendar year following the date of the enactment of this  
6 Act. The Secretary shall first issue all regulations nec-  
7 essary to carry out the amendments made by this subtitle  
8 before such date.

9 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
10 enforcement action shall be taken, pursuant to the amend-  
11 ments made by this subtitle, against a group health plan  
12 or health insurance issuer with respect to a violation of  
13 a requirement imposed by such amendments before the  
14 date of issuance of final regulations issued in connection  
15 with such requirement, if the plan or issuer has sought  
16 to comply in good faith with such requirement.

17 (c) COLLECTIVE BARGAINING AGREEMENTS.—Any  
18 plan amendment made pursuant to a collective bargaining  
19 agreement relating to the plan which amends the plan  
20 solely to conform to any requirement added by this subtitle  
21 shall not be treated as a termination of such collective bar-  
22 gaining agreement.

1 **Subtitle D—Affordable Health Cov-**  
 2 **erage for Employees of Small**  
 3 **Businesses**

4 **SEC. 1301. SHORT TITLE OF SUBTITLE.**

5 This subtitle may be cited as the “Small Business  
 6 Affordable Health Coverage Act of 1998”.

7 **SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH**  
 8 **PLANS.**

9 (a) IN GENERAL.—Subtitle B of title I of the Em-  
 10 ployee Retirement Income Security Act of 1974 is amend-  
 11 ed by adding after part 7 the following new part:

12 “PART 8—RULES GOVERNING ASSOCIATION HEALTH  
 13 PLANS

14 **“SEC. 801. ASSOCIATION HEALTH PLANS.**

15 “(a) IN GENERAL.—For purposes of this part, the  
 16 term ‘association health plan’ means a group health  
 17 plan—

18 “(1) whose sponsor is (or is deemed under this  
 19 part to be) described in subsection (b); and

20 “(2) under which at least one option of health  
 21 insurance coverage offered by a health insurance  
 22 issuer (which may include, among other options,  
 23 managed care options, point of service options, and  
 24 preferred provider options) is provided to partici-  
 25 pants and beneficiaries, unless, for any plan year,

1       such coverage remains unavailable to the plan de-  
2       spite good faith efforts exercised by the plan to se-  
3       cure such coverage.

4       “(b) SPONSORSHIP.—The sponsor of a group health  
5 plan is described in this subsection if such sponsor—

6               “(1) is organized and maintained in good faith,  
7       with a constitution and bylaws specifically stating its  
8       purpose and providing for periodic meetings on at  
9       least an annual basis, as a trade association, an in-  
10      dustry association (including a rural electric cooper-  
11      ative association or a rural telephone cooperative as-  
12      sociation), a professional association, or a chamber  
13      of commerce (or similar business association, includ-  
14      ing a corporation or similar organization that oper-  
15      ates on a cooperative basis (within the meaning of  
16      section 1381 of the Internal Revenue Code of  
17      1986)), for substantial purposes other than that of  
18      obtaining or providing medical care;

19              “(2) is established as a permanent entity which  
20      receives the active support of its members and col-  
21      lects from its members on a periodic basis dues or  
22      payments necessary to maintain eligibility for mem-  
23      bership in the sponsor; and

24              “(3) does not condition membership, such dues  
25      or payments, or coverage under the plan on the

1 basis of health status-related factors with respect to  
2 the employees of its members (or affiliated mem-  
3 bers), or the dependents of such employees, and does  
4 not condition such dues or payments on the basis of  
5 group health plan participation.

6 Any sponsor consisting of an association of entities which  
7 meet the requirements of paragraphs (1) and (2) shall be  
8 deemed to be a sponsor described in this subsection.

9 **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
10 **PLANS.**

11 “(a) IN GENERAL.—The applicable authority shall  
12 prescribe by regulation a procedure under which, subject  
13 to subsection (b), the applicable authority shall certify as-  
14 sociation health plans which apply for certification as  
15 meeting the requirements of this part.

16 “(b) STANDARDS.—Under the procedure prescribed  
17 pursuant to subsection (a), the applicable authority shall  
18 certify an association health plan as meeting the require-  
19 ments of this part only if the applicable authority is satis-  
20 fied that—

21 “(1) such certification—

22 “(A) is administratively feasible;

23 “(B) is not adverse to the interests of the  
24 individuals covered under the plan; and

1           “(C) is protective of the rights and benefits  
2           of the individuals covered under the plan; and

3           “(2) the applicable requirements of this part  
4           are met (or, upon the date on which the plan is to  
5           commence operations, will be met) with respect to  
6           the plan.

7           “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
8 PLANS.—An association health plan with respect to which  
9 certification under this part is in effect shall meet the ap-  
10 plicable requirements of this part, effective on the date  
11 of certification (or, if later, on the date on which the plan  
12 is to commence operations).

13          “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
14 CATION.—The applicable authority may provide by regula-  
15 tion for continued certification of association health plans  
16 under this part, including requirements relating to com-  
17 mencement of new benefit options by plans which do not  
18 consist of health insurance coverage.

19          “(e) CLASS CERTIFICATION FOR FULLY INSURED  
20 PLANS.—The applicable authority shall establish a class  
21 certification procedure for association health plans under  
22 which all benefits consist of health insurance coverage.  
23 Under such procedure, the applicable authority shall pro-  
24 vide for the granting of certification under this part to  
25 the plans in each class of such association health plans

1 upon appropriate filing under such procedure in connec-  
2 tion with plans in such class and payment of the pre-  
3 scribed fee under section 807(a).

4 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
5 **BOARDS OF TRUSTEES.**

6 “(a) SPONSOR.—The requirements of this subsection  
7 are met with respect to an association health plan if—

8 “(1) the sponsor (together with its immediate  
9 predecessor, if any) has met (or is deemed under  
10 this part to have met) for a continuous period of not  
11 less than 3 years ending with the date of the appli-  
12 cation for certification under this part, the require-  
13 ments of paragraphs (1) and (2) of section 801(b);  
14 and

15 “(2) the sponsor meets (or is deemed under this  
16 part to meet) the requirements of section 801(b)(3).

17 “(b) BOARD OF TRUSTEES.—The requirements of  
18 this subsection are met with respect to an association  
19 health plan if the following requirements are met:

20 “(1) FISCAL CONTROL.—The plan is operated,  
21 pursuant to a trust agreement, by a board of trust-  
22 ees which has complete fiscal control over the plan  
23 and which is responsible for all operations of the  
24 plan.



1           “(2) RULES OF OPERATION AND FINANCIAL  
2           CONTROLS.—The board of trustees has in effect  
3           rules of operation and financial controls, based on a  
4           3-year plan of operation, adequate to carry out the  
5           terms of the plan and to meet all requirements of  
6           this title applicable to the plan.

7           “(3) RULES GOVERNING RELATIONSHIP TO  
8           PARTICIPATING EMPLOYERS AND TO CONTRAC-  
9           TORS.—

10           “(A) IN GENERAL.—Except as provided in  
11           subparagraph (B), the members of the board of  
12           trustees are individuals selected from individ-  
13           uals who are the owners, officers, directors, or  
14           employees of the participating employers or who  
15           are partners in the participating employers and  
16           actively participate in the business.

17           “(B) LIMITATION.—

18           “(i) GENERAL RULE.—Except as pro-  
19           vided in clauses (ii) and (iii), no such  
20           member is an owner, officer, director, or  
21           employee of, or partner in, a contract ad-  
22           ministrator or other service provider to the  
23           plan.

24           “(ii) LIMITED EXCEPTION FOR PRO-  
25           VIDERS OF SERVICES SOLELY ON BEHALF

1                   OF THE SPONSOR.—Officers or employees  
2                   of a sponsor which is a service provider  
3                   (other than a contract administrator) to  
4                   the plan may be members of the board if  
5                   they constitute not more than 25 percent  
6                   of the membership of the board and they  
7                   do not provide services to the plan other  
8                   than on behalf of the sponsor.

9                   “(iii) TREATMENT OF PROVIDERS OF  
10                  MEDICAL CARE.—In the case of a sponsor  
11                  which is an association whose membership  
12                  consists primarily of providers of medical  
13                  care, clause (i) shall not apply in the case  
14                  of any service provider described in sub-  
15                  paragraph (A) who is a provider of medical  
16                  care under the plan.

17                  “(C) SOLE AUTHORITY.—The board has  
18                  sole authority to approve applications for par-  
19                  ticipation in the plan and to contract with a  
20                  service provider to administer the day-to-day af-  
21                  fairs of the plan.

22                  “(c) TREATMENT OF FRANCHISE NETWORKS.—In  
23                  the case of a group health plan which is established and  
24                  maintained by a franchiser for a franchise network con-  
25                  sisting of its franchisees—

1           “(1) the requirements of subsection (a) and sec-  
2           tion 801(a)(1) shall be deemed met if such require-  
3           ments would otherwise be met if the franchiser were  
4           deemed to be the sponsor referred to in section  
5           801(b), such network were deemed to be an associa-  
6           tion described in section 801(b), and each franchisee  
7           were deemed to be a member (of the association and  
8           the sponsor) referred to in section 801(b); and

9           “(2) the requirements of section 804(a)(1) shall  
10          be deemed met.

11          “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

12                 “(1) IN GENERAL.—In the case of a group  
13          health plan described in paragraph (2)—

14                         “(A) the requirements of subsection (a)  
15                         and section 801(a)(1) shall be deemed met;

16                         “(B) the joint board of trustees shall be  
17                         deemed a board of trustees with respect to  
18                         which the requirements of subsection (b) are  
19                         met; and

20                         “(C) the requirements of section 804 shall  
21                         be deemed met.

22                 “(2) REQUIREMENTS.—A group health plan is  
23          described in this paragraph if—

24                         “(A) the plan is a multiemployer plan; or

1           “(B) the plan is in existence on April 1,  
2           1997, and would be described in section  
3           3(40)(A)(i) but solely for the failure to meet  
4           the requirements of section 3(40)(C)(ii).

5   **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
6           **MENTS.**

7           “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
8           requirements of this subsection are met with respect to  
9           an association health plan if, under the terms of the  
10          plan—

11           “(1) all participating employers must be mem-  
12          bers or affiliated members of the sponsor, except  
13          that, in the case of a sponsor which is a professional  
14          association or other individual-based association, if  
15          at least one of the officers, directors, or employees  
16          of an employer, or at least one of the individuals  
17          who are partners in an employer and who actively  
18          participates in the business, is a member or affili-  
19          ated member of the sponsor, participating employers  
20          may also include such employer; and

21           “(2) all individuals commencing coverage under  
22          the plan after certification under this part must  
23          be—

24           “(A) active or retired owners (including  
25          self-employed individuals), officers, directors, or

1 employees of, or partners in, participating em-  
2 ployers; or

3 “(B) the beneficiaries of individuals de-  
4 scribed in subparagraph (A).

5 “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
6 PLOYEES.—

7 “(1) IN GENERAL.—Subject to paragraph (2),  
8 the requirements of this subsection are met with re-  
9 spect to an association health plan if, under the  
10 terms of the plan, no affiliated member of the spon-  
11 sor may be offered coverage under the plan as a par-  
12 ticipating employer, unless—

13 “(A) the affiliated member was an affili-  
14 ated member on the date of certification under  
15 this part; or

16 “(B) during the 12-month period preced-  
17 ing the date of the offering of such coverage,  
18 the affiliated member has not maintained or  
19 contributed to a group health plan with respect  
20 to any of its employees who would otherwise be  
21 eligible to participate in such association health  
22 plan.

23 “(2) LIMITATION.—The requirements of this  
24 subsection shall apply only in the case of plans  
25 which were in existence on the date of the enactment

1 of the Small Business Affordable Health Coverage  
2 Act of 1998.

3 “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
4 quirements of this subsection are met with respect to an  
5 association health plan if, under the terms of the plan,  
6 no participating employer may provide health insurance  
7 coverage in the individual market for any employee not  
8 covered under the plan which is similar to the coverage  
9 contemporaneously provided to employees of the employer  
10 under the plan, if such exclusion of the employee from cov-  
11 erage under the plan is based on a health status-related  
12 factor with respect to the employee and such employee  
13 would, but for such exclusion on such basis, be eligible  
14 for coverage under the plan.

15 “(d) PROHIBITION OF DISCRIMINATION AGAINST  
16 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-  
17 PATE.—The requirements of this subsection are met with  
18 respect to an association health plan if—

19 “(1) under the terms of the plan, no employer  
20 meeting the preceding requirements of this section is  
21 excluded as a participating employer, unless partici-  
22 pation or contribution requirements of the type re-  
23 ferred to in section 2711 of the Public Health Serv-  
24 ice Act are not met with respect to the excluded em-  
25 ployer;

1           “(2) the applicable requirements of sections  
2       701, 702, and 703 are met with respect to the plan;  
3       and

4           “(3) applicable benefit options under the plan  
5       are actively marketed to all eligible participating em-  
6       ployers.

7       **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
8                       **DOCUMENTS, CONTRIBUTION RATES, AND**  
9                       **BENEFIT OPTIONS.**

10       “(a) IN GENERAL.—The requirements of this section  
11       are met with respect to an association health plan if the  
12       following requirements are met:

13           “(1) CONTENTS OF GOVERNING INSTRU-  
14       MENTS.—The instruments governing the plan in-  
15       clude a written instrument, meeting the require-  
16       ments of an instrument required under section  
17       402(a)(1), which—

18           “(A) provides that the board of trustees  
19       serves as the named fiduciary required for plans  
20       under section 402(a)(1) and serves in the ca-  
21       pacity of a plan administrator (referred to in  
22       section 3(16)(A));

23           “(B) provides that the sponsor of the plan  
24       is to serve as plan sponsor (referred to in sec-  
25       tion 3(16)(B)); and

1           “(C) incorporates the requirements of sec-  
2           tion 806.

3           “(2) CONTRIBUTION RATES MUST BE NON-  
4           DISCRIMINATORY.—

5           “(A) The contribution rates for any par-  
6           ticipating small employer do not vary on the  
7           basis of the claims experience of such employer  
8           and do not vary on the basis of the type of  
9           business or industry in which such employer is  
10          engaged.

11          “(B) Nothing in this title or any other pro-  
12          vision of law shall be construed to preclude an  
13          association health plan, or a health insurance  
14          issuer offering health insurance coverage in  
15          connection with an association health plan,  
16          from—

17                 “(i) setting contribution rates based  
18                 on the claims experience of the plan; or

19                 “(ii) varying contribution rates for  
20                 small employers in a State to the extent  
21                 that such rates could vary using the same  
22                 methodology employed in such State for  
23                 regulating premium rates in the small  
24                 group market,



1 subject to the requirements of section 702(b)  
2 relating to contribution rates.

3 “(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
4 any benefit option under the plan does not consist  
5 of health insurance coverage, the plan has as of the  
6 beginning of the plan year not fewer than 1,000 participants and beneficiaries.

7  
8  
9 “(4) MARKETING REQUIREMENTS.—

10 “(A) IN GENERAL.—If a benefit option  
11 which consists of health insurance coverage is  
12 offered under the plan, State-licensed insurance  
13 agents shall be used to distribute to small employers coverage which does not consist of  
14 health insurance coverage in a manner comparable to the manner in which such agents are  
15 used to distribute health insurance coverage.

16  
17  
18 “(B) STATE-LICENSED INSURANCE  
19 AGENTS.—For purposes of subparagraph (A),  
20 the term ‘State-licensed insurance agents’  
21 means one or more agents who are licensed in  
22 a State and are subject to the laws of such  
23 State relating to licensure, qualification, testing, examination, and continuing education of  
24

1 persons authorized to offer, sell, or solicit  
 2 health insurance coverage in such State.

3 “(5) REGULATORY REQUIREMENTS.—Such  
 4 other requirements as the applicable authority may  
 5 prescribe by regulation as necessary to carry out the  
 6 purposes of this part.

7 “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
 8 DESIGN BENEFIT OPTIONS.—Nothing in this part or any  
 9 provision of State law (as defined in section 514(c)(1))  
 10 shall be construed to preclude an association health plan,  
 11 or a health insurance issuer offering health insurance cov-  
 12 erage in connection with an association health plan, from  
 13 exercising its sole discretion in selecting the specific items  
 14 and services consisting of medical care to be included as  
 15 benefits under such plan or coverage, except (subject to  
 16 section 514) in the case of any law to the extent that it  
 17 (1) prohibits an exclusion of a specific disease from such  
 18 coverage, or (2) is not preempted under section 731(a)(1)  
 19 with respect to matters governed by section 711 or 712.

20 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
 21 **FOR SOLVENCY FOR PLANS PROVIDING**  
 22 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
 23 **INSURANCE COVERAGE.**

24 “(a) IN GENERAL.—The requirements of this section  
 25 are met with respect to an association health plan if—

1           “(1) the benefits under the plan consist solely  
2 of health insurance coverage; or

3           “(2) if the plan provides any additional benefit  
4 options which do not consist of health insurance cov-  
5 erage, the plan—

6           “(A) establishes and maintains reserves  
7 with respect to such additional benefit options,  
8 in amounts recommended by the qualified actu-  
9 ary, consisting of—

10           “(i) a reserve sufficient for unearned  
11 contributions;

12           “(ii) a reserve sufficient for benefit li-  
13 abilities which have been incurred, which  
14 have not been satisfied, and for which risk  
15 of loss has not yet been transferred, and  
16 for expected administrative costs with re-  
17 spect to such benefit liabilities;

18           “(iii) a reserve sufficient for any other  
19 obligations of the plan; and

20           “(iv) a reserve sufficient for a margin  
21 of error and other fluctuations, taking into  
22 account the specific circumstances of the  
23 plan; and

24           “(B) establishes and maintains aggregate  
25 and specific excess/stop loss insurance and sol-

1 vency indemnification, with respect to such ad-  
2 ditional benefit options for which risk of loss  
3 has not yet been transferred, as follows:

4 “(i) The plan shall secure aggregate  
5 excess/stop loss insurance for the plan  
6 with an attachment point which is not  
7 greater than 125 percent of expected gross  
8 annual claims. The applicable authority  
9 may by regulation provide for upward ad-  
10 justments in the amount of such percent-  
11 age in specified circumstances in which the  
12 plan specifically provides for and maintains  
13 reserves in excess of the amounts required  
14 under subparagraph (A).

15 “(ii) The plan shall secure specific ex-  
16 cess/stop loss insurance for the plan with  
17 an attachment point which is at least equal  
18 to an amount recommended by the plan’s  
19 qualified actuary (but not more than  
20 \$200,000). The applicable authority may  
21 by regulation provide for adjustments in  
22 the amount of such insurance in specified  
23 circumstances in which the plan specifically  
24 provides for and maintains reserves in ex-

1                   cess of the amounts required under sub-  
2                   paragraph (A).

3                   “(iii) The plan shall secure indem-  
4                   nification insurance for any claims which  
5                   the plan is unable to satisfy by reason of  
6                   a plan termination.

7 Any regulations prescribed by the applicable authority  
8 pursuant to clause (i) or (ii) of subparagraph (B) may  
9 allow for such adjustments in the required levels of excess/  
10 stop loss insurance as the qualified actuary may rec-  
11 ommend, taking into account the specific circumstances  
12 of the plan.

13           “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS  
14 RESERVES.—The requirements of this subsection are met  
15 if the plan establishes and maintains surplus in an amount  
16 at least equal to \$2,000,000, reduced in accordance with  
17 a scale, prescribed in regulations of the applicable author-  
18 ity to an amount not less than \$500,000, based on the  
19 level of aggregate and specific excess/stop loss insurance  
20 provided with respect to such plan.

21           “(c) ADDITIONAL REQUIREMENTS.—In the case of  
22 any association health plan described in subsection (a)(2),  
23 the applicable authority may provide such additional re-  
24 quirements relating to reserves and excess/stop loss insur-  
25 ance as the applicable authority considers appropriate.

1 Such requirements may be provided, by regulation or oth-  
2 erwise, with respect to any such plan or any class of such  
3 plans.

4 “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-  
5 ANCE.—The applicable authority may provide for adjust-  
6 ments to the levels of reserves otherwise required under  
7 subsections (a) and (b) with respect to any plan or class  
8 of plans to take into account excess/stop loss insurance  
9 provided with respect to such plan or plans.

10 “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
11 applicable authority may permit an association health plan  
12 described in subsection (a)(2) to substitute, for all or part  
13 of the requirements of this section (except subsection  
14 (a)(2)(B)(iii)), such security, guarantee, hold-harmless ar-  
15 rangement, or other financial arrangement as the applica-  
16 ble authority determines to be adequate to enable the plan  
17 to fully meet all its financial obligations on a timely basis  
18 and is otherwise no less protective of the interests of par-  
19 ticipants and beneficiaries than the requirements for  
20 which it is substituted. The applicable authority may take  
21 into account, for purposes of this subsection, evidence pro-  
22 vided by the plan or sponsor which demonstrates an as-  
23 sumption of liability with respect to the plan. Such evi-  
24 dence may be in the form of a contract of indemnification,  
25 lien, bonding, insurance, letter of credit, recourse under

1 applicable terms of the plan in the form of assessments  
2 of participating employers, security, or other financial ar-  
3 rangement.

4 “(f) MEASURES TO ENSURE CONTINUED PAYMENT  
5 OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

6 “(1) PAYMENTS BY CERTAIN PLANS TO ASSO-  
7 CIATION HEALTH PLAN FUND.—

8 “(A) IN GENERAL.—In the case of an as-  
9 sociation health plan described in subsection  
10 (a)(2), the requirements of this subsection are  
11 met if the plan makes payments into the Asso-  
12 ciation Health Plan Fund under this subpara-  
13 graph when they are due. Such payments shall  
14 consist of annual payments in the amount of  
15 \$5,000, and, in addition to such annual pay-  
16 ments, such supplemental payments as the Sec-  
17 retary may determine to be necessary under  
18 paragraph (2). Payments under this paragraph  
19 are payable to the Fund at the time determined  
20 by the Secretary. Initial payments are due in  
21 advance of certification under this part. Pay-  
22 ments shall continue to accrue until a plan’s as-  
23 sets are distributed pursuant to a termination  
24 procedure.

1           “(B) PENALTIES FOR FAILURE TO MAKE  
2           PAYMENTS.—If any payment is not made by a  
3           plan when it is due, a late payment charge of  
4           not more than 100 percent of the payment  
5           which was not timely paid shall be payable by  
6           the plan to the Fund.

7           “(C) CONTINUED DUTY OF THE SEC-  
8           RETARY.—The Secretary shall not cease to  
9           carry out the provisions of paragraph (2) on ac-  
10          count of the failure of a plan to pay any pay-  
11          ment when due.

12          “(2) PAYMENTS BY SECRETARY TO CONTINUE  
13          EXCESS/STOP LOSS INSURANCE COVERAGE AND IN-  
14          DEMNIFICATION INSURANCE COVERAGE FOR CER-  
15          TAIN PLANS.—In any case in which the applicable  
16          authority determines that there is, or that there is  
17          reason to believe that there will be: (A) a failure to  
18          take necessary corrective actions under section  
19          809(a) with respect to an association health plan de-  
20          scribed in subsection (a)(2); or (B) a termination of  
21          such a plan under section 809(b) or 810(b)(8) (and,  
22          if the applicable authority is not the Secretary, cer-  
23          tifies such determination to the Secretary), the Sec-  
24          retary shall determine the amounts necessary to  
25          make payments to an insurer (designated by the



1 Secretary) to maintain in force excess/stop loss in-  
2 surance coverage or indemnification insurance cov-  
3 erage for such plan, if the Secretary determines that  
4 there is a reasonable expectation that, without such  
5 payments, claims would not be satisfied by reason of  
6 termination of such coverage. The Secretary shall, to  
7 the extent provided in advance in appropriation  
8 Acts, pay such amounts so determined to the insurer  
9 designated by the Secretary.

10 “(3) ASSOCIATION HEALTH PLAN FUND.—

11 “(A) IN GENERAL.—There is established  
12 on the books of the Treasury a fund to be  
13 known as the ‘Association Health Plan Fund’.  
14 The Fund shall be available for making pay-  
15 ments pursuant to paragraph (2). The Fund  
16 shall be credited with payments received pursu-  
17 ant to paragraph (1)(A), penalties received pur-  
18 suant to paragraph (1)(B); and earnings on in-  
19 vestments of amounts of the Fund under sub-  
20 paragraph (B).

21 “(B) INVESTMENT.—Whenever the Sec-  
22 retary determines that the moneys of the fund  
23 are in excess of current needs, the Secretary  
24 may request the investment of such amounts as  
25 the Secretary determines advisable by the Sec-

1           retary of the Treasury in obligations issued or  
2           guaranteed by the United States.

3           “(g) EXCESS/STOP LOSS INSURANCE.—For pur-  
4 poses of this section—

5           “(1) AGGREGATE EXCESS/STOP LOSS INSUR-  
6 ANCE.—The term ‘aggregate excess/stop loss insur-  
7 ance’ means, in connection with an association  
8 health plan, a contract—

9           “(A) under which an insurer (meeting such  
10 minimum standards as may be prescribed in regula-  
11 tions of the applicable authority) provides for pay-  
12 ment to the plan with respect to aggregate claims  
13 under the plan in excess of an amount or amounts  
14 specified in such contract;

15           “(B) which is guaranteed renewable; and

16           “(C) which allows for payment of premiums by  
17 any third party on behalf of the insured plan.

18           “(2) SPECIFIC EXCESS/STOP LOSS INSUR-  
19 ANCE.—The term ‘specific excess/stop loss insur-  
20 ance’ means, in connection with an association  
21 health plan, a contract—

22           “(A) under which an insurer (meeting such  
23 minimum standards as may be prescribed in  
24 regulations of the applicable authority) provides  
25 for payment to the plan with respect to claims

1 under the plan in connection with a covered in-  
2 dividual in excess of an amount or amounts  
3 specified in such contract in connection with  
4 such covered individual;

5 “(B) which is guaranteed renewable; and

6 “(C) which allows for payment of pre-  
7 miums by any third party on behalf of the in-  
8 sured plan.

9 “(h) INDEMNIFICATION INSURANCE.—For purposes  
10 of this section, the term ‘indemnification insurance’  
11 means, in connection with an association health plan, a  
12 contract—

13 “(1) under which an insurer (meeting such min-  
14 imum standards as may be prescribed in regulations  
15 of the applicable authority) provides for payment to  
16 the plan with respect to claims under the plan which  
17 the plan is unable to satisfy by reason of a termi-  
18 nation pursuant to section 809(b) (relating to man-  
19 datory termination);

20 “(2) which is guaranteed renewable and  
21 noncancellable for any reason (except as may be pro-  
22 vided in regulations of the applicable authority); and

23 “(3) which allows for payment of premiums by  
24 any third party on behalf of the insured plan.

1       “(i) RESERVES.—For purposes of this section, the  
2 term ‘reserves’ means, in connection with an association  
3 health plan, plan assets which meet the fiduciary stand-  
4 ards under part 4 and such additional requirements re-  
5 garding liquidity as may be prescribed in regulations of  
6 the applicable authority.

7       “(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED  
8 RULEMAKING.—The regulations under this sec-  
9 tion shall be prescribed under negotiated rulemaking in  
10 accordance with subchapter III of chapter 5 of title 5,  
11 United States Code, except that, in establishing the nego-  
12 tiated rulemaking committee for purposes of such rule-  
13 making, the applicable authority shall include among per-  
14 sons invited to membership on the committee at least one  
15 of each of the following:

16               “(1) a representative of the National Associa-  
17 tion of Insurance Commissioners;

18               “(2) a representative of the American Academy  
19 of Actuaries;

20               “(3) a representative of the State governments,  
21 or their interests;

22               “(4) a representative of existing self-insured ar-  
23 rangements, or their interests;

1 “(5) a representative of associations of the type  
2 referred to in section 801(b)(1), or their interests;  
3 and

4 “(6) a representative of multiemployer plans  
5 that are group health plans, or their interests.

6 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELAT-**  
7 **ED REQUIREMENTS.**

8 “(a) **FILING FEE.**—Under the procedure prescribed  
9 pursuant to section 802(a), an association health plan  
10 shall pay to the applicable authority at the time of filing  
11 an application for certification under this part a filing fee  
12 in the amount of \$5,000, which shall be available in the  
13 case of the Secretary, to the extent provided in appropria-  
14 tion Acts, for the sole purpose of administering the certifi-  
15 cation procedures applicable with respect to association  
16 health plans.

17 “(b) **INFORMATION TO BE INCLUDED IN APPLICA-**  
18 **TION FOR CERTIFICATION.**—An application for certifi-  
19 cation under this part meets the requirements of this sec-  
20 tion only if it includes, in a manner and form prescribed  
21 in regulations of the applicable authority, at least the fol-  
22 lowing information:

23 “(1) **IDENTIFYING INFORMATION.**—The names  
24 and addresses of—

25 “(A) the sponsor; and

1                   “(B) the members of the board of trustees  
2                   of the plan.

3                   “(2) STATES IN WHICH PLAN INTENDS TO DO  
4                   BUSINESS.—The States in which participants and  
5                   beneficiaries under the plan are to be located and  
6                   the number of them expected to be located in each  
7                   such State.

8                   “(3) BONDING REQUIREMENTS.—Evidence pro-  
9                   vided by the board of trustees that the bonding re-  
10                  quirements of section 412 will be met as of the date  
11                  of the application or (if later) commencement of op-  
12                  erations.

13                  “(4) PLAN DOCUMENTS.—A copy of the docu-  
14                  ments governing the plan (including any bylaws and  
15                  trust agreements), the summary plan description,  
16                  and other material describing the benefits that will  
17                  be provided to participants and beneficiaries under  
18                  the plan.

19                  “(5) AGREEMENTS WITH SERVICE PROVID-  
20                  ERS.—A copy of any agreements between the plan  
21                  and contract administrators and other service pro-  
22                  viders.

23                  “(6) FUNDING REPORT.—In the case of asso-  
24                  ciation health plans providing benefits options in ad-  
25                  dition to health insurance coverage, a report setting

1        forth information with respect to such additional  
2        benefit options determined as of a date within the  
3        120-day period ending with the date of the applica-  
4        tion, including the following:

5                “(A) RESERVES.—A statement, certified  
6                by the board of trustees of the plan, and a  
7                statement of actuarial opinion, signed by a  
8                qualified actuary, that all applicable require-  
9                ments of section 806 are or will be met in ac-  
10              cordance with regulations which the applicable  
11              authority shall prescribe.

12              “(B) ADEQUACY OF CONTRIBUTION  
13              RATES.—A statement of actuarial opinion,  
14              signed by a qualified actuary, which sets forth  
15              a description of the extent to which contribution  
16              rates are adequate to provide for the payment  
17              of all obligations and the maintenance of re-  
18              quired reserves under the plan for the 12-  
19              month period beginning with such date within  
20              such 120-day period, taking into account the  
21              expected coverage and experience of the plan. If  
22              the contribution rates are not fully adequate,  
23              the statement of actuarial opinion shall indicate  
24              the extent to which the rates are inadequate  
25              and the changes needed to ensure adequacy.

1                   “(C) CURRENT AND PROJECTED VALUE OF  
2                   ASSETS AND LIABILITIES.—A statement of ac-  
3                   tuarial opinion signed by a qualified actuary,  
4                   which sets forth the current value of the assets  
5                   and liabilities accumulated under the plan and  
6                   a projection of the assets, liabilities, income,  
7                   and expenses of the plan for the 12-month pe-  
8                   riod referred to in subparagraph (B). The in-  
9                   come statement shall identify separately the  
10                  plan’s administrative expenses and claims.

11                  “(D) COSTS OF COVERAGE TO BE  
12                  CHARGED AND OTHER EXPENSES.—A state-  
13                  ment of the costs of coverage to be charged, in-  
14                  cluding an itemization of amounts for adminis-  
15                  tration, reserves, and other expenses associated  
16                  with the operation of the plan.

17                  “(E) OTHER INFORMATION.—Any other  
18                  information which may be prescribed in regula-  
19                  tions of the applicable authority as necessary to  
20                  carry out the purposes of this part.

21                  “(c) FILING NOTICE OF CERTIFICATION WITH  
22                  STATES.—A certification granted under this part to an  
23                  association health plan shall not be effective unless written  
24                  notice of such certification is filed with the applicable  
25                  State authority of each State in which at least 25 percent



1 of the participants and beneficiaries under the plan are  
2 located. For purposes of this subsection, an individual  
3 shall be considered to be located in the State in which a  
4 known address of such individual is located or in which  
5 such individual is employed.

6 “(d) NOTICE OF MATERIAL CHANGES.—In the case  
7 of any association health plan certified under this part,  
8 descriptions of material changes in any information which  
9 was required to be submitted with the application for the  
10 certification under this part shall be filed in such form  
11 and manner as shall be prescribed in regulations of the  
12 applicable authority. The applicable authority may require  
13 by regulation prior notice of material changes with respect  
14 to specified matters which might serve as the basis for  
15 suspension or revocation of the certification.

16 “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
17 SOCIATION HEALTH PLANS.—An association health plan  
18 certified under this part which provides benefit options in  
19 addition to health insurance coverage for such plan year  
20 shall meet the requirements of section 103 by filing an  
21 annual report under such section which shall include infor-  
22 mation described in subsection (b)(6) with respect to the  
23 plan year and, notwithstanding section 104(a)(1)(A), shall  
24 be filed with the applicable authority not later than 90

1 days after the close of the plan year (or on such later date  
2 as may be prescribed by the applicable authority).

3 “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
4 board of trustees of each association health plan which  
5 provides benefits options in addition to health insurance  
6 coverage and which is applying for certification under this  
7 part or is certified under this part shall engage, on behalf  
8 of all participants and beneficiaries, a qualified actuary  
9 who shall be responsible for the preparation of the mate-  
10 rials comprising information necessary to be submitted by  
11 a qualified actuary under this part. The qualified actuary  
12 shall utilize such assumptions and techniques as are nec-  
13 essary to enable such actuary to form an opinion as to  
14 whether the contents of the matters reported under this  
15 part—

16 “(1) are in the aggregate reasonably related to  
17 the experience of the plan and to reasonable expecta-  
18 tions; and

19 “(2) represent such actuary’s best estimate of  
20 anticipated experience under the plan.

21 The opinion by the qualified actuary shall be made with  
22 respect to, and shall be made a part of, the annual report.

1   **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
2                                   **MINATION.**

3           “Except as provided in section 809(b), an association  
4 health plan which is or has been certified under this part  
5 may terminate (upon or at any time after cessation of ac-  
6 cruals in benefit liabilities) only if the board of trustees—

7                   “(1) not less than 60 days before the proposed  
8           termination date, provides to the participants and  
9           beneficiaries a written notice of intent to terminate  
10          stating that such termination is intended and the  
11          proposed termination date;

12                   “(2) develops a plan for winding up the affairs  
13          of the plan in connection with such termination in  
14          a manner which will result in timely payment of all  
15          benefits for which the plan is obligated; and

16                   “(3) submits such plan in writing to the appli-  
17          cable authority.

18          Actions required under this section shall be taken in such  
19          form and manner as may be prescribed in regulations of  
20          the applicable authority.

21   **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-**  
22                                   **NATION.**

23           “(a) ACTIONS TO AVOID DEPLETION OF RE-  
24          SERVES.—An association health plan which is certified  
25          under this part and which provides benefits other than  
26          health insurance coverage shall continue to meet the re-

1 requirements of section 806, irrespective of whether such  
2 certification continues in effect. The board of trustees of  
3 such plan shall determine quarterly whether the require-  
4 ments of section 806 are met. In any case in which the  
5 board determines that there is reason to believe that there  
6 is or will be a failure to meet such requirements, or the  
7 applicable authority makes such a determination and so  
8 notifies the board, the board shall immediately notify the  
9 qualified actuary engaged by the plan, and such actuary  
10 shall, not later than the end of the next following month,  
11 make such recommendations to the board for corrective  
12 action as the actuary determines necessary to ensure com-  
13 pliance with section 806. Not later than 30 days after re-  
14 ceiving from the actuary recommendations for corrective  
15 actions, the board shall notify the applicable authority (in  
16 such form and manner as the applicable authority may  
17 prescribe by regulation) of such recommendations of the  
18 actuary for corrective action, together with a description  
19 of the actions (if any) that the board has taken or plans  
20 to take in response to such recommendations. The board  
21 shall thereafter report to the applicable authority, in such  
22 form and frequency as the applicable authority may speci-  
23 fy to the board, regarding corrective action taken by the  
24 board until the requirements of section 806 are met.

1       “(b) MANDATORY TERMINATION.—In any case in  
2 which—

3               “(1) the applicable authority has been notified  
4       under subsection (a) of a failure of an association  
5       health plan which is or has been certified under this  
6       part and is described in section 806(a)(2) to meet  
7       the requirements of section 806 and has not been  
8       notified by the board of trustees of the plan that  
9       corrective action has restored compliance with such  
10      requirements; and

11              “(2) the applicable authority determines that  
12      there is a reasonable expectation that the plan will  
13      continue to fail to meet the requirements of section  
14      806,

15      the board of trustees of the plan shall, at the direction  
16      of the applicable authority, terminate the plan and, in the  
17      course of the termination, take such actions as the appli-  
18      cable authority may require, including satisfying any  
19      claims referred to in section 806(a)(2)(B)(iii) and recover-  
20      ing for the plan any liability under subsection  
21      (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure  
22      that the affairs of the plan will be, to the maximum extent  
23      possible, wound up in a manner which will result in timely  
24      provision of all benefits for which the plan is obligated.

1 **“SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOL-**  
2 **VENT ASSOCIATION HEALTH PLANS PROVID-**  
3 **ING HEALTH BENEFITS IN ADDITION TO**  
4 **HEALTH INSURANCE COVERAGE.**

5       “(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR  
6 INSOLVENT PLANS.—Whenever the Secretary determines  
7 that an association health plan which is or has been cer-  
8 tified under this part and which is described in section  
9 806(a)(2) will be unable to provide benefits when due or  
10 is otherwise in a financially hazardous condition as defined  
11 in regulations of such Secretary, the Secretary shall, upon  
12 notice to the plan, apply to the appropriate United States  
13 district court for appointment of the Secretary as trustee  
14 to administer the plan for the duration of the insolvency.  
15 The plan may appear as a party and other interested per-  
16 sons may intervene in the proceedings at the discretion  
17 of the court. The court shall appoint such Secretary trust-  
18 ee if the court determines that the trusteeship is necessary  
19 to protect the interests of the participants and bene-  
20 ficiaries or providers of medical care or to avoid any un-  
21 reasonable deterioration of the financial condition of the  
22 plan. The trusteeship of such Secretary shall continue  
23 until the conditions described in the first sentence of this  
24 subsection are remedied or the plan is terminated.

1       “(b) POWERS AS TRUSTEE.—The Secretary, upon  
2 appointment as trustee under subsection (a), shall have  
3 the power—

4           “(1) to do any act authorized by the plan, this  
5 title, or other applicable provisions of law to be done  
6 by the plan administrator or any trustee of the plan;

7           “(2) to require the transfer of all (or any part)  
8 of the assets and records of the plan to the Sec-  
9 retary as trustee;

10          “(3) to invest any assets of the plan which the  
11 Secretary holds in accordance with the provisions of  
12 the plan, regulations of the Secretary, and applicable  
13 provisions of law;

14          “(4) to require the sponsor, the plan adminis-  
15 trator, any participating employer, and any employee  
16 organization representing plan participants to fur-  
17 nish any information with respect to the plan which  
18 the Secretary as trustee may reasonably need in  
19 order to administer the plan;

20          “(5) to collect for the plan any amounts due the  
21 plan and to recover reasonable expenses of the trust-  
22 eeship;

23          “(6) to commence, prosecute, or defend on be-  
24 half of the plan any suit or proceeding involving the  
25 plan;

1 “(7) to issue, publish, or file such notices, state-  
2 ments, and reports as may be required under regula-  
3 tions of the Secretary or by any order of the court;

4 “(8) to terminate the plan (or provide for its  
5 termination accordance with section 809(b)) and liq-  
6 uidate the plan assets, to restore the plan to the re-  
7 sponsibility of the sponsor, or to continue the trust-  
8 eeship;

9 “(9) to provide for the enrollment of plan par-  
10 ticipants and beneficiaries under appropriate cov-  
11 erage options; and

12 “(10) to do such other acts as may be nec-  
13 essary to comply with this title or any order of the  
14 court and to protect the interests of plan partici-  
15 pants and beneficiaries and providers of medical  
16 care.

17 “(c) NOTICE OF APPOINTMENT.—As soon as prac-  
18 ticable after the Secretary’s appointment as trustee, the  
19 Secretary shall give notice of such appointment to—

20 “(1) the sponsor and plan administrator;

21 “(2) each participant;

22 “(3) each participating employer; and

23 “(4) if applicable, each employee organization  
24 which, for purposes of collective bargaining, rep-  
25 resents plan participants.



1       “(d) ADDITIONAL DUTIES.—Except to the extent in-  
2 consistent with the provisions of this title, or as may be  
3 otherwise ordered by the court, the Secretary, upon ap-  
4 pointment as trustee under this section, shall be subject  
5 to the same duties as those of a trustee under section 704  
6 of title 11, United States Code, and shall have the duties  
7 of a fiduciary for purposes of this title.

8       “(e) OTHER PROCEEDINGS.—An application by the  
9 Secretary under this subsection may be filed notwithstand-  
10 ing the pendency in the same or any other court of any  
11 bankruptcy, mortgage foreclosure, or equity receivership  
12 proceeding, or any proceeding to reorganize, conserve, or  
13 liquidate such plan or its property, or any proceeding to  
14 enforce a lien against property of the plan.

15       “(f) JURISDICTION OF COURT.—

16               “(1) IN GENERAL.—Upon the filing of an appli-  
17 cation for the appointment as trustee or the issuance  
18 of a decree under this section, the court to which the  
19 application is made shall have exclusive jurisdiction  
20 of the plan involved and its property wherever lo-  
21 cated with the powers, to the extent consistent with  
22 the purposes of this section, of a court of the United  
23 States having jurisdiction over cases under chapter  
24 11 of title 11, United States Code. Pending an adju-  
25 dication under this section such court shall stay, and

1       upon appointment by it of the Secretary as trustee,  
2       such court shall continue the stay of, any pending  
3       mortgage foreclosure, equity receivership, or other  
4       proceeding to reorganize, conserve, or liquidate the  
5       plan, the sponsor, or property of such plan or spon-  
6       sor, and any other suit against any receiver, con-  
7       servator, or trustee of the plan, the sponsor, or  
8       property of the plan or sponsor. Pending such adju-  
9       dication and upon the appointment by it of the Sec-  
10      retary as trustee, the court may stay any proceeding  
11      to enforce a lien against property of the plan or the  
12      sponsor or any other suit against the plan or the  
13      sponsor.

14           “(2) VENUE.—An action under this section  
15      may be brought in the judicial district where the  
16      sponsor or the plan administrator resides or does  
17      business or where any asset of the plan is situated.  
18      A district court in which such action is brought may  
19      issue process with respect to such action in any  
20      other judicial district.

21           “(g) PERSONNEL.—In accordance with regulations of  
22      the Secretary, the Secretary shall appoint, retain, and  
23      compensate accountants, actuaries, and other professional  
24      service personnel as may be necessary in connection with  
25      the Secretary’s service as trustee under this section.

1 **“SEC. 811. STATE ASSESSMENT AUTHORITY.**

2       “(a) IN GENERAL.—Notwithstanding section 514, a  
3 State may impose by law a contribution tax on an associa-  
4 tion health plan described in section 806(a)(2), if the plan  
5 commenced operations in such State after the date of the  
6 enactment of the Small Business Affordable Health Cov-  
7 erage Act of 1998.

8       “(b) CONTRIBUTION TAX.—For purposes of this sec-  
9 tion, the term ‘contribution tax’ imposed by a State on  
10 an association health plan means any tax imposed by such  
11 State if—

12               “(1) such tax is computed by applying a rate to  
13 the amount of premiums or contributions, with re-  
14 spect to individuals covered under the plan who are  
15 residents of such State, which are received by the  
16 plan from participating employers located in such  
17 State or from such individuals;

18               “(2) the rate of such tax does not exceed the  
19 rate of any tax imposed by such State on premiums  
20 or contributions received by insurers or health main-  
21 tenance organizations for health insurance coverage  
22 offered in such State in connection with a group  
23 health plan;

24               “(3) such tax is otherwise nondiscriminatory;  
25 and

1           “(4) the amount of any such tax assessed on  
2           the plan is reduced by the amount of any tax or as-  
3           sessment otherwise imposed by the State on pre-  
4           miums, contributions, or both received by insurers or  
5           health maintenance organizations for health insur-  
6           ance coverage, aggregate excess/stop loss insurance  
7           (as defined in section 806(g)(1)), specific excess/  
8           stop loss insurance (as defined in section 806(g)(2)),  
9           other insurance related to the provision of medical  
10          care under the plan, or any combination thereof pro-  
11          vided by such insurers or health maintenance organi-  
12          zations in such State in connection with such plan.

13   **“SEC. 812. SPECIAL RULES FOR CHURCH PLANS.**

14          “(a) ELECTION FOR CHURCH PLANS.—Notwith-  
15       standing section 4(b)(2), if a church, a convention or asso-  
16       ciation of churches, or an organization described in section  
17       3(33)(C)(i) maintains a church plan which is a group  
18       health plan (as defined in section 733(a)(1)), and such  
19       church, convention, association, or organization makes an  
20       election with respect to such plan under this subsection  
21       (in such form and manner as the Secretary may by regula-  
22       tion prescribe), then the provisions of this section shall  
23       apply to such plan, with respect to benefits provided under  
24       such plan consisting of medical care, as if section 4(b)(2)  
25       did not contain an exclusion for church plans. Nothing in

1 this subsection shall be construed to render any other sec-  
2 tion of this title applicable to church plans, except to the  
3 extent that such other section is incorporated by reference  
4 in this section.

5 “(b) EFFECT OF ELECTION.—

6 “(1) PREEMPTION OF STATE INSURANCE LAWS  
7 REGULATING COVERED CHURCH PLANS.—Subject to  
8 paragraphs (2) and (3), this section shall supersede  
9 any and all State laws which regulate insurance in-  
10 sofar as they may now or hereafter regulate church  
11 plans to which this section applies or trusts estab-  
12 lished under such church plans.

13 “(2) GENERAL STATE INSURANCE REGULATION  
14 UNAFFECTED.—

15 “(A) IN GENERAL.—Except as provided in  
16 subparagraph (B) and paragraph (3), nothing  
17 in this section shall be construed to exempt or  
18 relieve any person from any provision of State  
19 law which regulates insurance.

20 “(B) CHURCH PLANS NOT TO BE DEEMED  
21 INSURANCE COMPANIES OR INSURERS.—Neither  
22 a church plan to which this section applies, nor  
23 any trust established under such a church plan,  
24 shall be deemed to be an insurance company or  
25 other insurer or to be engaged in the business

1 of insurance for purposes of any State law pur-  
2 porting to regulate insurance companies or in-  
3 surance contracts.

4 “(3) PREEMPTION OF CERTAIN STATE LAWS  
5 RELATING TO PREMIUM RATE REGULATION AND  
6 BENEFIT MANDATES.—The provisions of subsections  
7 (a)(2)(B) and (b) of section 805 shall apply with re-  
8 spect to a church plan to which this section applies  
9 in the same manner and to the same extent as such  
10 provisions apply with respect to association health  
11 plans.

12 “(4) DEFINITIONS.—For purposes of this sub-  
13 section—

14 “(A) STATE LAW.—The term ‘State law’  
15 includes all laws, decisions, rules, regulations,  
16 or other State action having the effect of law,  
17 of any State. A law of the United States appli-  
18 cable only to the District of Columbia shall be  
19 treated as a State law rather than a law of the  
20 United States.

21 “(B) STATE.—The term ‘State’ includes a  
22 State, any political subdivision thereof, or any  
23 agency or instrumentality of either, which pur-  
24 ports to regulate, directly or indirectly, the

1 terms and conditions of church plans covered by  
2 this section.

3 “(c) REQUIREMENTS FOR COVERED CHURCH  
4 PLANS.—

5 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-  
6 POSE.—A fiduciary shall discharge his duties with  
7 respect to a church plan to which this section ap-  
8 plies—

9 “(A) for the exclusive purpose of:

10 “(i) providing benefits to participants  
11 and their beneficiaries; and

12 “(ii) defraying reasonable expenses of  
13 administering the plan;

14 “(B) with the care, skill, prudence and dili-  
15 gence under the circumstances then prevailing  
16 that a prudent man acting in a like capacity  
17 and familiar with such matters would use in the  
18 conduct of an enterprise of a like character and  
19 with like aims; and

20 “(C) in accordance with the documents  
21 and instruments governing the plan.

22 The requirements of this paragraph shall not be  
23 treated as not satisfied solely because the plan as-  
24 sets are commingled with other church assets, to the

1 extent that such plan assets are separately ac-  
2 counted for.

3 “(2) CLAIMS PROCEDURE.—In accordance with  
4 regulations of the Secretary, every church plan to  
5 which this section applies shall—

6 “(A) provide adequate notice in writing to  
7 any participant or beneficiary whose claim for  
8 benefits under the plan has been denied, setting  
9 forth the specific reasons for such denial, writ-  
10 ten in a manner calculated to be understood by  
11 the participant;

12 “(B) afford a reasonable opportunity to  
13 any participant whose claim for benefits has  
14 been denied for a full and fair review by the ap-  
15 propriate fiduciary of the decision denying the  
16 claim; and

17 “(C) provide a written statement to each  
18 participant describing the procedures estab-  
19 lished pursuant to this paragraph.

20 “(3) ANNUAL STATEMENTS.—In accordance  
21 with regulations of the Secretary, every church plan  
22 to which this section applies shall file with the Sec-  
23 retary an annual statement—

24 “(A) stating the names and addresses of  
25 the plan and of the church, convention, or asso-



1 ciation maintaining the plan (and its principal  
2 place of business);

3 “(B) certifying that it is a church plan to  
4 which this section applies and that it complies  
5 with the requirements of paragraphs (1) and  
6 (2);

7 “(C) identifying the States in which par-  
8 ticipants and beneficiaries under the plan are or  
9 likely will be located during the 1-year period  
10 covered by the statement; and

11 “(D) containing a copy of a statement of  
12 actuarial opinion signed by a qualified actuary  
13 that the plan maintains capital, reserves, insur-  
14 ance, other financial arrangements, or any com-  
15 bination thereof adequate to enable the plan to  
16 fully meet all of its financial obligations on a  
17 timely basis.

18 “(4) DISCLOSURE.—At the time that the an-  
19 nual statement is filed by a church plan with the  
20 Secretary pursuant to paragraph (3), a copy of such  
21 statement shall be made available by the Secretary  
22 to the State insurance commissioner (or similar offi-  
23 cial) of any State. The name of each church plan  
24 and sponsoring organization filing an annual state-

1       ment in compliance with paragraph (3) shall be pub-  
2       lished annually in the Federal Register.

3       “(c) ENFORCEMENT.—The Secretary may enforce  
4 the provisions of this section in a manner consistent with  
5 section 502, to the extent applicable with respect to ac-  
6 tions under section 502(a)(5), and with section 3(33)(D),  
7 except that, other than for the purpose of seeking a tem-  
8 porary restraining order, a civil action may be brought  
9 with respect to the plan’s failure to meet any requirement  
10 of this section only if the plan fails to correct its failure  
11 within the correction period described in section 3(33)(D).  
12 The other provisions of part 5 (except sections 501(a),  
13 503, 512, 514, and 515) shall apply with respect to the  
14 enforcement and administration of this section.

15       “(d) DEFINITIONS AND OTHER RULES.—For pur-  
16 poses of this section—

17               “(1) IN GENERAL.—Except as otherwise pro-  
18 vided in this section, any term used in this section  
19 which is defined in any provision of this title shall  
20 have the definition provided such term by such pro-  
21 vision.

22               “(2) SEMINARY STUDENTS.—Seminary students  
23 who are enrolled in an institution of higher learning  
24 described in section 3(33)(C)(iv) and who are treat-  
25 ed as participants under the terms of a church plan

1 to which this section applies shall be deemed to be  
2 employees as defined in section 3(6) if the number  
3 of such students constitutes an insignificant portion  
4 of the total number of individuals who are treated  
5 as participants under the terms of the plan.

6 **“SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.**

7 “(a) DEFINITIONS.—For purposes of this part—

8 “(1) GROUP HEALTH PLAN.—The term ‘group  
9 health plan’ has the meaning provided in section  
10 733(a)(1) (after applying subsection (b) of this sec-  
11 tion).

12 “(2) MEDICAL CARE.—The term ‘medical care’  
13 has the meaning provided in section 733(a)(2).

14 “(3) HEALTH INSURANCE COVERAGE.—The  
15 term ‘health insurance coverage’ has the meaning  
16 provided in section 733(b)(1).

17 “(4) HEALTH INSURANCE ISSUER.—The term  
18 ‘health insurance issuer’ has the meaning provided  
19 in section 733(b)(2).

20 “(5) APPLICABLE AUTHORITY.—

21 “(A) IN GENERAL.—Except as provided in  
22 subparagraph (B), the term ‘applicable author-  
23 ity’ means, in connection with an association  
24 health plan—

1 “(i) the State recognized pursuant to  
 2 subsection (c) of section 506 as the State  
 3 to which authority has been delegated in  
 4 connection with such plan; or

5 “(ii) if there if no State referred to in  
 6 clause (i), the Secretary.

7 “(B) EXCEPTIONS.—

8 “(i) JOINT AUTHORITIES.—Where  
 9 such term appears in section 808(3), sec-  
 10 tion 807(e) (in the first instance), section  
 11 809(a) (in the second instance), section  
 12 809(a) (in the fourth instance), and sec-  
 13 tion 809(b)(1), such term means, in con-  
 14 nection with an association health plan, the  
 15 Secretary and the State referred to in sub-  
 16 paragraph (A)(i) (if any) in connection  
 17 with such plan.

18 “(ii) REGULATORY AUTHORITIES.—  
 19 Where such term appears in section 802(a)  
 20 (in the first instance), section 802(d), sec-  
 21 tion 802(e), section 803(d), section  
 22 805(a)(5), section 806(a)(2), section  
 23 806(b), section 806(c), section 806(d),  
 24 paragraphs (1)(A) and (2)(A) of section  
 25 806(g), section 806(h), section 806(i), sec-

tion 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

“(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

“(7) INDIVIDUAL MARKET.—

“(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) TREATMENT OF VERY SMALL GROUPS.—

“(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

1                   “(ii) STATE EXCEPTION.—Clause (i)  
2                   shall not apply in the case of health insur-  
3                   ance coverage offered in a State if such  
4                   State regulates the coverage described in  
5                   such clause in the same manner and to the  
6                   same extent as coverage in the small group  
7                   market (as defined in section 2791(e)(5) of  
8                   the Public Health Service Act) is regulated  
9                   by such State.

10                  “(8) PARTICIPATING EMPLOYER.—The term  
11                  ‘participating employer’ means, in connection with  
12                  an association health plan, any employer, if any indi-  
13                  vidual who is an employee of such employer, a part-  
14                  ner in such employer, or a self-employed individual  
15                  who is such employer (or any dependent, as defined  
16                  under the terms of the plan, of such individual) is  
17                  or was covered under such plan in connection with  
18                  the status of such individual as such an employee,  
19                  partner, or self-employed individual in relation to the  
20                  plan.

21                  “(9) APPLICABLE STATE AUTHORITY.—The  
22                  term ‘applicable State authority’ means, with respect  
23                  to a health insurance issuer in a State, the State in-  
24                  surance commissioner or official or officials des-  
25                  ignated by the State to enforce the requirements of

1 title XXVII of the Public Health Service Act for the  
2 State involved with respect to such issuer.

3 “(10) QUALIFIED ACTUARY.—The term ‘quali-  
4 fied actuary’ means an individual who is a member  
5 of the American Academy of Actuaries or meets  
6 such reasonable standards and qualifications as the  
7 Secretary may provide by regulation.

8 “(11) AFFILIATED MEMBER.—The term ‘affili-  
9 ated member’ means, in connection with a sponsor,  
10 a person eligible to be a member of the sponsor or,  
11 in the case of a sponsor with member associations,  
12 a person who is a member, or is eligible to be a  
13 member, of a member association.

14 “(12) LARGE EMPLOYER.—The term ‘large em-  
15 ployer’ means, in connection with a group health  
16 plan with respect to a plan year, an employer who  
17 employed an average of at least 51 employees on  
18 business days during the preceding calendar year  
19 and who employs at least 2 employees on the first  
20 day of the plan year.

21 “(13) SMALL EMPLOYER.—The term ‘small em-  
22 ployer’ means, in connection with a group health  
23 plan with respect to a plan year, an employer who  
24 is not a large employer.

25 “(b) RULES OF CONSTRUCTION.—

1           “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
2           poses of determining whether a plan, fund, or pro-  
3           gram is an employee welfare benefit plan which is an  
4           association health plan, and for purposes of applying  
5           this title in connection with such plan, fund, or pro-  
6           gram so determined to be such an employee welfare  
7           benefit plan—

8                   “(A) in the case of a partnership, the term  
9                   ‘employer’ (as defined in section (3)(5)) in-  
10                  cludes the partnership in relation to the part-  
11                  ners, and the term ‘employee’ (as defined in  
12                  section (3)(6)) includes any partner in relation  
13                  to the partnership; and

14                  “(B) in the case of a self-employed individ-  
15                  ual, the term ‘employer’ (as defined in section  
16                  3(5)) and the term ‘employee’ (as defined in  
17                  section 3(6)) shall include such individual.

18           “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
19           AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
20           case of any plan, fund, or program which was estab-  
21           lished or is maintained for the purpose of providing  
22           medical care (through the purchase of insurance or  
23           otherwise) for employees (or their dependents) cov-  
24           ered thereunder and which demonstrates to the Sec-  
25           retary that all requirements for certification under



1       this part would be met with respect to such plan,  
 2       fund, or program if such plan, fund, or program  
 3       were a group health plan, such plan, fund, or pro-  
 4       gram shall be treated for purposes of this title as an  
 5       employee welfare benefit plan on and after the date  
 6       of such demonstration.”.

7       (b) CONFORMING AMENDMENTS TO PREEMPTION  
 8 RULES.—

9               (1) Section 514(b)(6) of such Act (29 U.S.C.  
 10       1144(b)(6)) is amended by adding at the end the  
 11       following new subparagraph:

12       “(E) The preceding subparagraphs of this paragraph  
 13       do not apply with respect to any State law in the case  
 14       of an association health plan which is certified under part  
 15       8.”.

16              (2) Section 514 of such Act (29 U.S.C. 1144)  
 17       is amended—

18                   (A) in subsection (b)(4), by striking “Sub-  
 19       section (a)” and inserting “Subsections (a) and  
 20       (d)”;

21                   (B) in subsection (b)(5), by striking “sub-  
 22       section (a)” in subparagraph (A) and inserting  
 23       “subsection (a) of this section and subsections  
 24       (a)(2)(B) and (b) of section 805”, and by strik-  
 25       ing “subsection (a)” in subparagraph (B) and

1 inserting “subsection (a) of this section or sub-  
2 section (a)(2)(B) or (b) of section 805”;

3 (C) by redesignating subsection (d) as sub-  
4 section (e); and

5 (D) by inserting after subsection (c) the  
6 following new subsection:

7 “(d)(1) Except as provided in subsection (b)(4), the  
8 provisions of this title shall supersede any and all State  
9 laws insofar as they may now or hereafter preclude, or  
10 have the effect of precluding, a health insurance issuer  
11 from offering health insurance coverage in connection with  
12 an association health plan which is certified under part  
13 8.

14 “(2) Except as provided in paragraphs (4) and (5)  
15 of subsection (b) of this section—

16 “(A) In any case in which health insurance cov-  
17 erage of any policy type is offered under an associa-  
18 tion health plan certified under part 8 to a partici-  
19 pating employer operating in such State, the provi-  
20 sions of this title shall supersede any and all laws  
21 of such State insofar as they may preclude a health  
22 insurance issuer from offering health insurance cov-  
23 erage of the same policy type to other employers op-  
24 erating in the State which are eligible for coverage  
25 under such association health plan, whether or not

1       such other employers are participating employers in  
2       such plan.

3           “(B) In any case in which health insurance cov-  
4       erage of any policy type is offered under an associa-  
5       tion health plan in a State and the filing, with the  
6       applicable State authority, of the policy form in con-  
7       nection with such policy type is approved by such  
8       State authority, the provisions of this title shall su-  
9       persede any and all laws of any other State in which  
10      health insurance coverage of such type is offered, in-  
11      sofar as they may preclude, upon the filing in the  
12      same form and manner of such policy form with the  
13      applicable State authority in such other State, the  
14      approval of the filing in such other State.

15      “(3) For additional provisions relating to association  
16      health plans, see subsections (a)(2)(B) and (b) of section  
17      805.

18      “(4) For purposes of this subsection, the term ‘asso-  
19      ciation health plan’ has the meaning provided in section  
20      801(a), and the terms ‘health insurance coverage’, ‘par-  
21      ticipating employer’, and ‘health insurance issuer’ have  
22      the meanings provided such terms in section 811, respec-  
23      tively.”.

24           (3) Section 514(b)(6)(A) of such Act (29  
25      U.S.C. 1144(b)(6)(A)) is amended—

1 (A) in clause (i)(II), by striking “and” at  
2 the end;

3 (B) in clause (ii), by inserting “and which  
4 does not provide medical care (within the mean-  
5 ing of section 733(a)(2)),” after “arrange-  
6 ment,”, and by striking “title.” and inserting  
7 “title, and”; and

8 (C) by adding at the end the following new  
9 clause:

10 “(iii) subject to subparagraph (E), in the case  
11 of any other employee welfare benefit plan which is  
12 a multiple employer welfare arrangement and which  
13 provides medical care (within the meaning of section  
14 733(a)(2)), any law of any State which regulates in-  
15 surance may apply.”.

16 (4) Section 514(e) of such Act (as redesignated  
17 by paragraph (2)(C)) is amended—

18 (A) by striking “Nothing” and inserting  
19 “(1) Except as provided in paragraph (2), noth-  
20 ing”; and

21 (B) by adding at the end the following new  
22 paragraph:

23 “(2) Nothing in any other provision of law enacted  
24 on or after the date of the enactment of the Patient Pro-  
25 tection Act of 1998 shall be construed to alter, amend,

1 modify, invalidate, impair, or supersede any provision of  
 2 this title, except by specific cross-reference to the affected  
 3 section.”.

4 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
 5 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
 6 the following new sentence: “Such term also includes a  
 7 person serving as the sponsor of an association health plan  
 8 under part 8.”.

9 (d) DISCLOSURE OF SOLVENCY PROTECTIONS RE-  
 10 LATED TO SELF-INSURED AND FULLY INSURED OPTIONS  
 11 UNDER ASSOCIATION HEALTH PLANS.—Section 102(b)  
 12 of such Act (29 U.S.C. 102(b)) is amended by adding at  
 13 the end the following: “An association health plan shall  
 14 include in its summary plan description, in connection  
 15 with each benefit option, a description of the form of sol-  
 16 vency or guarantee fund protection secured pursuant to  
 17 this Act or applicable State law, if any.”.

18 (e) SAVINGS CLAUSE.—Section 731(c) of such Act is  
 19 amended by inserting “or part 8” after “this part”.

20 (f) CLERICAL AMENDMENT.—The table of contents  
 21 in section 1 of the Employee Retirement Income Security  
 22 Act of 1974 is amended by inserting after the item relat-  
 23 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

“Sec. 811. State assessment authority.

“Sec. 812. Special rules for church plans.

“Sec. 813. Definitions and rules of construction.”.

1   **SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
 2                                   **PLOYER ARRANGEMENTS.**

3           Section 3(40)(B) of the Employee Retirement Income  
 4   Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
 5   ed—

6                   (1) in clause (i), by inserting “for any plan year  
 7           of any such plan, or any fiscal year of any such  
 8           other arrangement;” after “single employer”, and by  
 9           inserting “during such year or at any time during  
 10          the preceding 1-year period” after “control group”;

11                  (2) in clause (iii)—

12                   (A) by striking “common control shall not  
 13           be based on an interest of less than 25 percent”  
 14           and inserting “an interest of greater than 25  
 15           percent may not be required as the minimum  
 16           interest necessary for common control”; and

17                   (B) by striking “similar to” and inserting  
 18           “consistent and coextensive with”;

1           (3) by redesignating clauses (iv) and (v) as  
2           clauses (v) and (vi), respectively; and

3           (4) by inserting after clause (iii) the following  
4           new clause:

5           “(iv) in determining, after the application of  
6           clause (i), whether benefits are provided to employ-  
7           ees of two or more employers, the arrangement shall  
8           be treated as having only one participating employer  
9           if, after the application of clause (i), the number of  
10          individuals who are employees and former employees  
11          of any one participating employer and who are cov-  
12          ered under the arrangement is greater than 75 per-  
13          cent of the aggregate number of all individuals who  
14          are employees or former employees of participating  
15          employers and who are covered under the arrange-  
16          ment;”.

17 **SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN**  
18 **COLLECTIVELY BARGAINED ARRANGE-**  
19 **MENTS.**

20          (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
21 ployee Retirement Income Security Act of 1974 (29  
22 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

23           “(i)(I) under or pursuant to one or more collec-  
24          tive bargaining agreements which are reached pursu-  
25          ant to collective bargaining described in section 8(d)

1 of the National Labor Relations Act (29 U.S.C.  
2 158(d)) or paragraph Fourth of section 2 of the  
3 Railway Labor Act (45 U.S.C. 152, paragraph  
4 Fourth) or which are reached pursuant to labor-  
5 management negotiations under similar provisions of  
6 State public employee relations laws, and (II) in ac-  
7 cordance with subparagraphs (C), (D), and (E);”.

8 (b) LIMITATIONS.—Section 3(40) of such Act (29  
9 U.S.C. 1002(40)) is amended by adding at the end the  
10 following new subparagraphs:

11 “(C) For purposes of subparagraph (A)(i)(II), a plan  
12 or other arrangement shall be treated as established or  
13 maintained in accordance with this subparagraph only if  
14 the following requirements are met:

15 “(i) The plan or other arrangement, and the  
16 employee organization or any other entity sponsoring  
17 the plan or other arrangement, do not—

18 “(I) utilize the services of any licensed in-  
19 surance agent or broker for soliciting or enroll-  
20 ing employers or individuals as participating  
21 employers or covered individuals under the plan  
22 or other arrangement; or

23 “(II) pay a commission or any other type  
24 of compensation to a person, other than a full  
25 time employee of the employee organization (or



1 a member of the organization to the extent pro-  
2 vided in regulations of the Secretary), that is  
3 related either to the volume or number of em-  
4 ployers or individuals solicited or enrolled as  
5 participating employers or covered individuals  
6 under the plan or other arrangement, or to the  
7 dollar amount or size of the contributions made  
8 by participating employers or covered individ-  
9 uals to the plan or other arrangement;

10 except to the extent that the services used by the  
11 plan, arrangement, organization, or other entity con-  
12 sist solely of preparation of documents necessary for  
13 compliance with the reporting and disclosure re-  
14 quirements of part 1 or administrative, investment,  
15 or consulting services unrelated to solicitation or en-  
16 rollment of covered individuals.

17 “(ii) As of the end of the preceding plan year,  
18 the number of covered individuals under the plan or  
19 other arrangement who are identified to the plan or  
20 arrangement and who are neither—

21 “(I) employed within a bargaining unit  
22 covered by any of the collective bargaining  
23 agreements with a participating employer (nor  
24 covered on the basis of an individual’s employ-  
25 ment in such a bargaining unit); nor

1           “(II) present employees (or former employ-  
2           ees who were covered while employed) of the  
3           sponsoring employee organization, of an em-  
4           ployer who is or was a party to any of the col-  
5           lective bargaining agreements, or of the plan or  
6           other arrangement or a related plan or arrange-  
7           ment (nor covered on the basis of such present  
8           or former employment);  
9           does not exceed 15 percent of the total number of  
10          individuals who are covered under the plan or ar-  
11          rangement and who are present or former employees  
12          who are or were covered under the plan or arrange-  
13          ment pursuant to a collective bargaining agreement  
14          with a participating employer. The requirements of  
15          the preceding provisions of this clause shall be treat-  
16          ed as satisfied if, as of the end of the preceding plan  
17          year, such covered individuals are comprised solely  
18          of individuals who were covered individuals under  
19          the plan or other arrangement as of the date of the  
20          enactment of the Small Business Affordable Health  
21          Coverage Act of 1998 and, as of the end of the pre-  
22          ceding plan year, the number of such covered indi-  
23          viduals does not exceed 25 percent of the total num-  
24          ber of present and former employees enrolled under  
25          the plan or other arrangement.

1           “(iii) The employee organization or other entity  
2           sponsoring the plan or other arrangement certifies  
3           to the Secretary each year, in a form and manner  
4           which shall be prescribed in regulations of the Sec-  
5           retary that the plan or other arrangement meets the  
6           requirements of clauses (i) and (ii).

7           “(D) For purposes of subparagraph (A)(i)(II), a plan  
8           or arrangement shall be treated as established or main-  
9           tained in accordance with this subparagraph only if—

10           “(i) all of the benefits provided under the plan  
11           or arrangement consist of health insurance coverage;  
12           or

13           “(ii)(I) the plan or arrangement is a multiem-  
14           ployer plan; and

15           “(II) the requirements of clause (B) of the pro-  
16           viso to clause (5) of section 302(c) of the Labor  
17           Management Relations Act, 1947 (29 U.S.C.  
18           186(c)) are met with respect to such plan or other  
19           arrangement.

20           “(E) For purposes of subparagraph (A)(i)(II), a plan  
21           or arrangement shall be treated as established or main-  
22           tained in accordance with this subparagraph only if—

23           “(i) the plan or arrangement is in effect as of  
24           the date of the enactment of the Small Business Af-  
25           fordable Health Coverage Act of 1998; or

1           “(ii) the employee organization or other entity  
2           sponsoring the plan or arrangement—

3                   “(I) has been in existence for at least 3  
4           years or is affiliated with another employee or-  
5           ganization which has been in existence for at  
6           least 3 years; or

7                   “(II) demonstrates to the satisfaction of  
8           the Secretary that the requirements of subpara-  
9           graphs (C) and (D) are met with respect to the  
10          plan or other arrangement.”.

11          (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
12 PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
13 Act (29 U.S.C. 1002(7)) is amended by adding at the end  
14 the following new sentence: “Such term includes an indi-  
15 vidual who is a covered individual described in paragraph  
16 (40)(C)(ii).”.

17 **SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
18 **CIATION HEALTH PLANS.**

19          (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
20 MISREPRESENTATIONS.—Section 501 of the Employee  
21 Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
22 is amended—

23                   (1) by inserting “(a)” after “SEC. 501.”; and

24                   (2) by adding at the end the following new sub-  
25          section:

1       “(b) Any person who, either willfully or with willful  
2 blindness, falsely represents, to any employee, any employ-  
3 ee’s beneficiary, any employer, the Secretary, or any State,  
4 a plan or other arrangement established or maintained for  
5 the purpose of offering or providing any benefit described  
6 in section 3(1) to employees or their beneficiaries as—

7               “(1) being an association health plan which has  
8 been certified under part 8;

9               “(2) having been established or maintained  
10 under or pursuant to one or more collective bargain-  
11 ing agreements which are reached pursuant to col-  
12 lective bargaining described in section 8(d) of the  
13 National Labor Relations Act (29 U.S.C. 158(d)) or  
14 paragraph Fourth of section 2 of the Railway Labor  
15 Act (45 U.S.C. 152, paragraph Fourth) or which are  
16 reached pursuant to labor-management negotiations  
17 under similar provisions of State public employee re-  
18 lations laws; or

19               “(3) being a plan or arrangement with respect  
20 to which the requirements of subparagraph (C), (D),  
21 or (E) of section 3(40) are met;

22 shall, upon conviction, be imprisoned not more than 5  
23 years, be fined under title 18, United States Code, or  
24 both.”.

1 (b) CEASE ACTIVITIES ORDERS.—Section 502 of  
2 such Act (29 U.S.C. 1132) is amended by adding at the  
3 end the following new subsection:

4 “(n)(1) Subject to paragraph (2), upon application  
5 by the Secretary showing the operation, promotion, or  
6 marketing of an association health plan (or similar ar-  
7 rangement providing benefits consisting of medical care  
8 (as defined in section 733(a)(2))) that—

9 “(A) is not certified under part 8, is subject  
10 under section 514(b)(6) to the insurance laws of any  
11 State in which the plan or arrangement offers or  
12 provides benefits, and is not licensed, registered, or  
13 otherwise approved under the insurance laws of such  
14 State; or

15 “(B) is an association health plan certified  
16 under part 8 and is not operating in accordance with  
17 the requirements under part 8 for such certification,  
18 a district court of the United States shall enter an order  
19 requiring that the plan or arrangement cease activities.

20 “(2) Paragraph (1) shall not apply in the case of an  
21 association health plan or other arrangement if the plan  
22 or arrangement shows that—

23 “(A) all benefits under it referred to in para-  
24 graph (1) consist of health insurance coverage; and

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—

Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

20 SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE  
21 AUTHORITIES.

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1       “(c) RESPONSIBILITY OF STATES WITH RESPECT TO  
2       ASSOCIATION HEALTH PLANS.—

3               “(1) AGREEMENTS WITH STATES.—A State  
4       may enter into an agreement with the Secretary for  
5       delegation to the State of some or all of—

6               “(A) the Secretary’s authority under sec-  
7       tions 502 and 504 to enforce the requirements  
8       for certification under part 8;

9               “(B) the Secretary’s authority to certify  
10      association health plans under part 8 in accord-  
11      ance with regulations of the Secretary applica-  
12      ble to certification under part 8; or

13              “(C) any combination of the Secretary’s  
14      authority authorized to be delegated under sub-  
15      paragraphs (A) and (B).

16              “(2) DELEGATIONS.—Any department, agency,  
17      or instrumentality of a State to which authority is  
18      delegated pursuant to an agreement entered into  
19      under this paragraph may, if authorized under State  
20      law and to the extent consistent with such agree-  
21      ment, exercise the powers of the Secretary under  
22      this title which relate to such authority.

23              “(3) RECOGNITION OF PRIMARY DOMICILE  
24      STATE.—In entering into any agreement with a  
25      State under subparagraph (A), the Secretary shall



1 ensure that, as a result of such agreement and all  
2 other agreements entered into under subparagraph  
3 (A), only one State will be recognized, with respect  
4 to any particular association health plan, as the  
5 State to which all authority has been delegated pur-  
6 suant to such agreements in connection with such  
7 plan. In carrying out this paragraph, the Secretary  
8 shall take into account the places of residence of the  
9 participants and beneficiaries under the plan and the  
10 State in which the trust is maintained.”.

11 **SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND**  
12 **OTHER RULES.**

13 (a) **EFFECTIVE DATE.**—The amendments made by  
14 sections 1302, 1305, and 1306 shall take effect on Janu-  
15 ary 1, 2000. The amendments made by sections 1303 and  
16 1304 shall take effect on the date of the enactment of  
17 this Act. The Secretary of Labor shall first issue all regu-  
18 lations necessary to carry out the amendments made by  
19 this subtitle before January 1, 2000.

20 (b) **EXCEPTION.**—Section 801(a)(2) of the Employee  
21 Retirement Income Security Act of 1974 (added by section  
22 1302) does not apply in connection with an association  
23 health plan (certified under part 8 of subtitle B of title  
24 I of such Act) existing on April 1, 1997, if no benefits  
25 provided thereunder as of the date of the enactment of

1 this Act consist of health insurance coverage (as defined  
2 in section 733(b)(1) of such Act).

3 (c) TREATMENT OF CERTAIN EXISTING HEALTH  
4 BENEFITS PROGRAMS.—

5 (1) IN GENERAL.—In any case in which, as of  
6 the date of the enactment of this Act, an arrange-  
7 ment is maintained in a State for the purpose of  
8 providing benefits consisting of medical care for the  
9 employees and beneficiaries of its participating em-  
10 ployers, at least 200 participating employers make  
11 contributions to such arrangement, such arrange-  
12 ment has been in existence for at least 10 years, and  
13 such arrangement is licensed under the laws of one  
14 or more States to provide such benefits to its par-  
15 ticipating employers, upon the filing with the appli-  
16 cable authority (as defined in section 813(a)(5) of  
17 the Employee Retirement Income Security Act of  
18 1974 (as amended by this Act)) by the arrangement  
19 of an application for certification of the arrangement  
20 under part 8 of subtitle B of title I of such Act—

21 (A) such arrangement shall be deemed to  
22 be a group health plan for purposes of title I  
23 of such Act;

24 (B) the requirements of sections 801(a)(1)  
25 and 803(a)(1) of the Employee Retirement In-

1           come Security Act of 1974 shall be deemed met  
2           with respect to such arrangement;

3           (C) the requirements of section 803(b) of  
4           such Act shall be deemed met, if the arrange-  
5           ment is operated by a board of directors  
6           which—

7                   (i) is elected by the participating em-  
8                   ployers, with each employer having one  
9                   vote; and

10                   (ii) has complete fiscal control over  
11                   the arrangement and which is responsible  
12                   for all operations of the arrangement;

13           (D) the requirements of section 804(a) of  
14           such Act shall be deemed met with respect to  
15           such arrangement; and

16           (E) the arrangement may be certified by  
17           any applicable authority with respect to its op-  
18           erations in any State only if it operates in such  
19           State on the date of certification.

20           The provisions of this subsection shall cease to apply  
21           with respect to any such arrangement at such time  
22           after the date of the enactment of this Act as the  
23           applicable requirements of this subsection are not  
24           met with respect to such arrangement.

1           (2) DEFINITIONS.—For purposes of this sub-  
2       section, the terms “group health plan”, “medical  
3       care”, and “participating employer” shall have the  
4       meanings provided in section 813 of the Employee  
5       Retirement Income Security Act of 1974, except  
6       that the reference in paragraph (7) of such section  
7       to an “association health plan” shall be deemed a  
8       reference to an arrangement referred to in this sub-  
9       section.

10       (d) PILOT PROGRAM FOR SELF-INSURED ASSOCIA-  
11   TION HEALTH PLANS.—

12           (1) IN GENERAL.—During the pilot program  
13       period, association health plans which offer benefit  
14       options which do not consist of health insurance cov-  
15       erage may be certified under part 8 of subtitle B of  
16       title I of the Employee Retirement Income Security  
17       Act of 1974 only if such plans consist of the follow-  
18       ing:

19           (A) plans which offered such coverage on  
20       the date of the enactment of this Act;

21           (B) plans under which the sponsor does  
22       not restrict membership to one or more trades  
23       and businesses or industries and whose eligible  
24       participating employers represent a broad cross-

1 section of trades and businesses or industries;  
2 or

3 (C) plans whose eligible participating em-  
4 ployers represent one or more trades or busi-  
5 nesses, or one or more industries, which have  
6 been indicated as having average or above-aver-  
7 age health insurance risk or health claims expe-  
8 rience by reason of State rate filings, denials of  
9 coverage, proposed premium rate levels, and  
10 other means demonstrated by such plans in ac-  
11 cordance with regulations which the Secretary  
12 shall prescribe, including (but not limited to)  
13 the following: agriculture; automobile dealer-  
14 ships; barbering and cosmetology; child care;  
15 construction; dance, theatrical, and orchestra  
16 productions; disinfecting and pest control; eat-  
17 ing and drinking establishments; fishing; hos-  
18 pitals; labor organizations; logging; manufactur-  
19 ing (metals); mining; medical and dental prac-  
20 tices; medical laboratories; sanitary services;  
21 transportation (local and freight); and  
22 warehousing.

23 (2) PILOT PROGRAM PERIOD.—For purposes of  
24 this subsection, the term “pilot program period”

1 means the 5-year period beginning on January 1,  
2 1999.

3 **TITLE II—AMENDMENTS TO**  
4 **PUBLIC HEALTH SERVICE ACT**  
5 **Subtitle A—Patient Protections**  
6 **and Point of Service Coverage**  
7 **Requirements**

8 **SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
9 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
10 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
11 **ATRIC CARE.**

12 (a) IN GENERAL.—Subpart 2 of part A of title  
13 XXVII of the Public Health Service Act is amended by  
14 adding at the end the following new section:

15 **“SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
16 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
17 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
18 **ATRIC CARE.**

19 **“(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
20 **ADVICE.—**

21 **“(1) IN GENERAL.—**In the case of any health  
22 care professional acting within the lawful scope of  
23 practice in the course of carrying out a contractual  
24 employment arrangement or other direct contractual  
25 arrangement between such professional and a group

1 health plan or a health insurance issuer offering  
2 health insurance coverage in connection with a group  
3 health plan, the plan or issuer with which such con-  
4 tractual employment arrangement or other direct  
5 contractual arrangement is maintained by the pro-  
6 fessional may not impose on such professional under  
7 such arrangement any prohibition or restriction with  
8 respect to advice, provided to a participant or bene-  
9 ficiary under the plan who is a patient, about the  
10 health status of the participant or beneficiary or the  
11 medical care or treatment for the condition or dis-  
12 ease of the participant or beneficiary, regardless of  
13 whether benefits for such care or treatment are pro-  
14 vided under the plan or health insurance coverage  
15 offered in connection with the plan.

16 “(2) HEALTH CARE PROFESSIONAL DEFINED.—  
17 For purposes of this subsection, the term ‘health  
18 care professional’ means a physician (as defined in  
19 section 1861(r) of the Social Security Act) or other  
20 health care professional if coverage for the profes-  
21 sional’s services is provided under the group health  
22 plan for the services of the professional. Such term  
23 includes a podiatrist, optometrist, chiropractor, psy-  
24 chologist, dentist, physician assistant, physical or oc-  
25 cupational therapist and therapy assistant, speech—

1 language pathologist, audiologist, registered or li-  
2 censed practical nurse (including nurse practitioner,  
3 clinical nurse specialist, certified registered nurse  
4 anesthetist, and certified nurse–midwife), licensed  
5 certified social worker, registered respiratory thera-  
6 pist, and certified respiratory therapy technician.

7 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
8 CARE.—

9 “(1) IN GENERAL.—To the extent that the  
10 group health plan (or health insurance issuer offer-  
11 ing health insurance coverage in connection with the  
12 plan) provides for any benefits consisting of emer-  
13 gency medical care (as defined in section  
14 503(b)(9)(I) of the Employee Retirement Income Se-  
15 curity Act of 1974), except for items or services spe-  
16 cifically excluded—

17 “(A) the plan or issuer shall provide bene-  
18 fits, without requiring preauthorization and  
19 without regard to otherwise applicable network  
20 limitations, for appropriate emergency medical  
21 screening examinations (within the capability of  
22 the emergency facility, including ancillary serv-  
23 ices routinely available to the emergency facil-  
24 ity) to the extent that a prudent layperson, who  
25 possesses an average knowledge of health and



1 medicine, would determine such examinations to  
2 be necessary in order to determine whether  
3 emergency medical care (as so defined) is re-  
4 quired; and

5 “(B) the plan or issuer shall provide bene-  
6 fits for additional emergency medical services  
7 following an emergency medical screening exam-  
8 ination (if determined necessary under subpara-  
9 graph (A)) to the extent that a prudent emer-  
10 gency medical professional would determine  
11 such additional emergency services to be nec-  
12 essary to avoid the consequences described in  
13 section 503(b)(9)(I) of such Act.

14 “(2) UNIFORM COST-SHARING REQUIRED.—

15 Nothing in this subsection shall be construed as pre-  
16 venting a group health plan or issuer from imposing  
17 any form of cost-sharing applicable to any partici-  
18 pant or beneficiary (including coinsurance, copay-  
19 ments, deductibles, and any other charges) in rela-  
20 tion to benefits described in paragraph (1), if such  
21 form of cost-sharing is uniformly applied under such  
22 plan, with respect to similarly situated participants  
23 and beneficiaries, to all benefits consisting of emer-  
24 gency medical care (as defined in section  
25 503(b)(9)(I) of the Employee Retirement Income Se-

1 curity Act of 1974) provided to such similarly situ-  
2 ated participants and beneficiaries under the plan.

3 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
4 LOGICAL CARE.—

5 “(1) IN GENERAL.—In any case in which a  
6 group health plan (or a health insurance issuer of-  
7 fering health insurance coverage in connection with  
8 the plan)—

9 “(A) provides benefits under the terms of  
10 the plan consisting of—

11 “(i) routine gynecological care (such  
12 as preventive women’s health examina-  
13 tions); or

14 “(ii) routine obstetric care (such as  
15 routine pregnancy-related services),  
16 provided by a participating physician who spe-  
17 cializes in such care (or provides benefits con-  
18 sisting of payment for such care); and

19 “(B) the plan requires or provides for des-  
20 ignation by a participant or beneficiary of a  
21 participating primary care provider,

22 if the primary care provider designated by such a  
23 participant or beneficiary is not such a physician,  
24 then the plan (or issuer) shall meet the requirements  
25 of paragraph (2).

1           “(2) REQUIREMENTS.—A group health plan (or  
2           a health insurance issuer offering health insurance  
3           coverage in connection with the plan) meets the re-  
4           quirements of this paragraph, in connection with  
5           benefits described in paragraph (1) consisting of  
6           care described in clause (i) or (ii) of paragraph  
7           (1)(A) (or consisting of payment therefor), if the  
8           plan (or issuer)—

9           “(A) does not require authorization or a  
10          referral by the primary care provider in order  
11          to obtain such benefits; and

12          “(B) treats the ordering of other routine  
13          care of the same type, by the participating phy-  
14          sician providing the care described in clause (i)  
15          or (ii) of paragraph (1)(A), as the authorization  
16          of the primary care provider with respect to  
17          such care.

18          “(3) CONSTRUCTION.—Nothing in paragraph  
19          (2)(B) shall waive any requirements of coverage re-  
20          lating to medical necessity or appropriateness with  
21          respect to coverage of gynecological or obstetric care  
22          so ordered.

23          “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

24          “(1) IN GENERAL.—In any case in which a  
25          group health plan (or a health insurance issuer of-

1       fering health insurance coverage in connection with  
 2       the plan) provides benefits consisting of routine pe-  
 3       diatric care provided by a participating physician  
 4       who specializes in pediatrics (or consisting of pay-  
 5       ment for such care) and the plan requires or pro-  
 6       vides for designation by a participant or beneficiary  
 7       of a participating primary care provider, the plan (or  
 8       issuer) shall provide that such a participating physi-  
 9       cian may be designated, if available, by a parent or  
 10      guardian of any beneficiary under the plan is who  
 11      under 18 years of age, as the primary care provider  
 12      with respect to any such benefits.

13           “(2) CONSTRUCTION.—Nothing in paragraph  
 14      (1) shall waive any requirements of coverage relating  
 15      to medical necessity or appropriateness with respect  
 16      to coverage of pediatric care.

17      “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
 18      TIONS.—In the case of a plan providing benefits under two  
 19      or more coverage options, the requirements of subsections  
 20      (c) and (d) shall apply separately with respect to each cov-  
 21      erage option.”.

22      “(c) EFFECTIVE DATE AND RELATED RULES.—

23           “(1) IN GENERAL.—The amendments made by  
 24      this section shall apply with respect to plan years be-  
 25      ginning on or after January 1 of the second cal-

1       endar year following the date of the enactment of  
2       this Act, except that the Secretary of Health and  
3       Human Services may issue regulations before such  
4       date under such amendments. The Secretary shall  
5       first issue all regulations necessary to carry out the  
6       amendments made by this section before the effec-  
7       tive date thereof.

8               (2) LIMITATION ON ENFORCEMENT ACTIONS.—

9       No enforcement action shall be taken, pursuant to  
10      the amendments made by this section, against a  
11      group health plan or health insurance issuer with re-  
12      spect to a violation of a requirement imposed by  
13      such amendments before the date of issuance of reg-  
14      ulations issued in connection with such requirement,  
15      if the plan or issuer has sought to comply in good  
16      faith with such requirement.

17              (3) SPECIAL RULE FOR COLLECTIVE BARGAIN-  
18      ING AGREEMENTS.—In the case of a group health  
19      plan maintained pursuant to one or more collective  
20      bargaining agreements between employee representa-  
21      tives and one or more employers ratified before the  
22      date of the enactment of this Act, the amendments  
23      made by this section shall not apply with respect to  
24      plan years beginning before the later of—

1           (1) the date on which the last of the collec-  
 2           tive bargaining agreements relating to the plan  
 3           terminates (determined without regard to any  
 4           extension thereof agreed to after the date of the  
 5           enactment of this Act); or

6           (2) January 1, 2001.

7           For purposes of this paragraph, any plan amend-  
 8           ments made pursuant to a collective bargaining  
 9           agreement relating to the plan which amends the  
 10          plan solely to conform to any requirement added by  
 11          this section shall not be treated as a termination of  
 12          such collective bargaining agreement.

13 **SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZA-**  
 14 **TIONS TO OFFER OPTION OF POINT-OF-SERV-**  
 15 **ICE COVERAGE.**

16          (a) IN GENERAL.—Title XXVII of the Public Health  
 17          Service Act is amended by inserting after section 2713 the  
 18          following new section:

19 **“SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-**  
 20 **OF-SERVICE COVERAGE.**

21          “(a) REQUIREMENT TO OFFER COVERAGE OPTION  
 22          TO CERTAIN EMPLOYERS.—Except as provided in sub-  
 23          section (c), any health insurance issuer which—

24                 “(1) is a health maintenance organization (as  
 25                 defined in section 2791(b)(3)); and

1           “(2) which provides for coverage of services of  
2           one or more classes of health care professionals  
3           under health insurance coverage offered in connec-  
4           tion with a group health plan only if such services  
5           are furnished exclusively through health care profes-  
6           sionals within such class or classes who are members  
7           of a closed panel of health care professionals,  
8           the issuer shall make available to the plan sponsor in con-  
9           nection with such a plan a coverage option which provides  
10          for coverage of such services which are furnished through  
11          such class (or classes) of health care professionals regard-  
12          less of whether or not the professionals are members of  
13          such panel.

14          “(b) REQUIREMENT TO OFFER SUPPLEMENTAL COV-  
15          ERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as  
16          provided in subsection (c), if a health insurance issuer  
17          makes available a coverage option under and described in  
18          subsection (a) to a plan sponsor of a group health plan  
19          and the sponsor declines to contract for such coverage op-  
20          tion, then the issuer shall make available in the individual  
21          insurance market to each participant in the group health  
22          plan optional separate supplemental health insurance cov-  
23          erage in the individual health insurance market which con-  
24          sists of services identical to those provided under such cov-  
25          erage provided through the closed panel under the group

1 health plan but are furnished exclusively by health care  
2 professionals who are not members of such a closed panel.

3 “(c) EXCEPTIONS.—

4 “(1) OFFERING OF NON-PANEL OPTION.—Sub-  
5 sections (a) and (b) shall not apply with respect to  
6 a group health plan if the plan offers a coverage op-  
7 tion that provides coverage for services that may be  
8 furnished by a class or classes of health care profes-  
9 sionals who are not in a closed panel. This para-  
10 graph shall be applied separately to distinguishable  
11 groups of employees under the plan.

12 “(2) AVAILABILITY OF COVERAGE THROUGH  
13 HEALTHMART.—Subsections (a) and (b) shall not  
14 apply to a group health plan if the health insurance  
15 coverage under the plan is made available through a  
16 HealthMart (as defined in section 2801) and if any  
17 health insurance coverage made available through  
18 the HealthMart provides for coverage of the services  
19 of any class of health care professionals other than  
20 through a closed panel of professionals.

21 “(3) RELICENSURE EXEMPTION.—Subsections  
22 (a) and (b) shall not apply to a health maintenance  
23 organization in a State in any case in which—

24 “(A) the organization demonstrates to the  
25 applicable authority that the organization has



1           made a good faith effort to obtain (but has  
2           failed to obtain) a contract between the organi-  
3           zation and any other health insurance issuer  
4           providing for the coverage option or supple-  
5           mental coverage described in subsection (a) or  
6           (b), as the case may be, within the applicable  
7           service area of the organization; and

8           “(B) the State requires the organization to  
9           receive or qualify for a separate license, as an  
10          indemnity insurer or otherwise, in order to offer  
11          such coverage option or supplemental coverage,  
12          respectively.

13       The applicable authority may require that the orga-  
14       nization demonstrate that it meets the requirements  
15       of the previous sentence no more frequently than  
16       once every 2 years.

17       “(4) INCREASED COSTS.—Subsections (a) and  
18       (b) shall not apply to a health maintenance organi-  
19       zation if the organization demonstrates to the appli-  
20       cable authority, in accordance with generally accept-  
21       ed actuarial practice, that, on either a prospective or  
22       retroactive basis, the premium for the coverage op-  
23       tion or supplemental coverage required to be made  
24       available under such respective subsection exceeds by  
25       more than 1 percent the premium for the coverage

1 consisting of services which are furnished through a  
2 closed panel of health care professionals in the class  
3 or classes involved. The applicable authority may re-  
4 quire that the organization demonstrate such an in-  
5 crease no more frequently than once every 2 years.  
6 This paragraph shall be applied on an average per  
7 enrollee or similar basis.

8 “(5) COLLECTIVE BARGAINING AGREEMENTS.—  
9 Subsections (a) and (b) shall not apply in connection  
10 with a group health plan if the plan is established  
11 or maintained pursuant to one or more collective  
12 bargaining agreements.

13 “(d) DEFINITIONS.—For purposes of this section:

14 “(1) COVERAGE THROUGH CLOSED PANEL.—  
15 Health insurance coverage for a class of health care  
16 professionals shall be treated as provided through a  
17 closed panel of such professionals only if such cov-  
18 erage consists of coverage of items or services con-  
19 sisting of professionals services which are reim-  
20 bursed for or provided only within a limited network  
21 of such professionals.

22 “(2) HEALTH CARE PROFESSIONAL.—The term  
23 ‘health care professional’ has the meaning given  
24 such term in section 2706(a)(2).”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to coverage offered on or after  
 3 January 1 of the second calendar year following the date  
 4 of the enactment of this Act.

5 **Subtitle B—Patient Access to**  
 6 **Information**

7 **SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING**  
 8 **PLAN COVERAGE, MANAGED CARE PROCE-**  
 9 **DURES, HEALTH CARE PROVIDERS, AND**  
 10 **QUALITY OF MEDICAL CARE.**

11 (a) IN GENERAL.—Subpart 2 of part A of title  
 12 XXVII of the Public Health Service Act (as amended by  
 13 subtitle A of this title) is amended further by adding at  
 14 the end the following new section:

15 **“SEC. 2707. PATIENT ACCESS TO INFORMATION REGARD-**  
 16 **ING PLAN COVERAGE, MANAGED CARE PRO-**  
 17 **CEDURES, HEALTH CARE PROVIDERS, AND**  
 18 **QUALITY OF MEDICAL CARE.**

19 “(a) DISCLOSURE REQUIREMENT.—Each health in-  
 20 surance issuer offering health insurance coverage in con-  
 21 nection with a group health plan shall provide the adminis-  
 22 trator of such plan on a timely basis with the information  
 23 necessary to enable the administrator to include in the  
 24 summary plan description of the plan required under sec-  
 25 tion 102 of the Employee Retirement Income Security Act

1 of 1974 (or each summary plan description in any case  
2 in which different summary plan descriptions are appro-  
3 priate under part 1 of subtitle B of title I of such Act  
4 for different options of coverage) the information required  
5 under subsections (b), (c), (d), and (e)(2)(A). To the ex-  
6 tent that any such issuer provides such information on a  
7 timely basis to plan participants and beneficiaries, the re-  
8 quirements of this subsection shall be deemed satisfied in  
9 the case of such plan with respect to such information.

10 “(b) PLAN BENEFITS.—The information required  
11 under subsection (a) includes the following:

12 “(1) COVERED ITEMS AND SERVICES.—

13 “(A) CATEGORIZATION OF INCLUDED BEN-  
14 EFITS.—A description of covered benefits, cat-  
15 egorized by—

16 “(i) types of items and services (in-  
17 cluding any special disease management  
18 program); and

19 “(ii) types of health care professionals  
20 providing such items and services.

21 “(B) EMERGENCY MEDICAL CARE.—A de-  
22 scription of the extent to which the coverage in-  
23 cludes emergency medical care (including the  
24 extent to which the coverage provides for access  
25 to urgent care centers), and any definitions pro-

1           vided under in connection with such coverage  
2           for the relevant coverage terminology referring  
3           to such care.

4           “(C) PREVENTATIVE SERVICES.—A de-  
5           scription of the extent to which the coverage in-  
6           cludes benefits for preventative services.

7           “(D) DRUG FORMULARIES.—A description  
8           of the extent to which covered benefits are de-  
9           termined by the use or application of a drug  
10          formulary and a summary of the process for de-  
11          termining what is included in such formulary.

12          “(E) COBRA CONTINUATION COV-  
13          ERAGE.—A description of the benefits available  
14          under the coverage provided pursuant to part 6  
15          of subtitle B of title I of the Employee Retire-  
16          ment Income Security Act of 1974.

17          “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
18          TIONS ON COVERED BENEFITS.—

19               “(A) CATEGORIZATION OF EXCLUDED  
20               BENEFITS.—A description of benefits specifi-  
21               cally excluded from coverage, categorized by  
22               types of items and services.

23               “(B) UTILIZATION REVIEW AND  
24               PREAUTHORIZATION REQUIREMENTS.—Whether  
25               coverage for medical care is limited or excluded

1 on the basis of utilization review or  
2 preauthorization requirements.

3 “(C) LIFETIME, ANNUAL, OR OTHER PE-  
4 RIOD LIMITATIONS.—A description of the cir-  
5 cumstances under which, and the extent to  
6 which, coverage is subject to lifetime, annual, or  
7 other period limitations, categorized by types of  
8 benefits.

9 “(D) CUSTODIAL CARE.—A description of  
10 the circumstances under which, and the extent  
11 to which, the coverage of benefits for custodial  
12 care is limited or excluded, and a statement of  
13 the definition used in connection with such cov-  
14 erage for custodial care.

15 “(E) EXPERIMENTAL TREATMENTS.—  
16 Whether coverage for any medical care is lim-  
17 ited or excluded because it constitutes experi-  
18 mental treatment or technology, and any defini-  
19 tions provided in connection with such coverage  
20 for the relevant plan terminology referring to  
21 such limited or excluded care.

22 “(F) MEDICAL APPROPRIATENESS OR NE-  
23 CESSITY.—Whether coverage for medical care  
24 may be limited or excluded by reason of a fail-  
25 ure to meet the plan’s requirements for medical

1       appropriateness or necessity, and any defini-  
2       tions provided in connection with such coverage  
3       for the relevant coverage terminology referring  
4       to such limited or excluded care.

5               “(G) SECOND OR SUBSEQUENT OPIN-  
6       IONS.—A description of the circumstances  
7       under which, and the extent to which, coverage  
8       for second or subsequent opinions is limited or  
9       excluded.

10              “(H) SPECIALTY CARE.—A description of  
11       the circumstances under which, and the extent  
12       to which, coverage of benefits for specialty care  
13       is conditioned on referral from a primary care  
14       provider.

15              “(I) CONTINUITY OF CARE.—A description  
16       of the circumstances under which, and the ex-  
17       tent to which, coverage of items and services  
18       provided by any health care professional is lim-  
19       ited or excluded by reason of the departure by  
20       the professional from any defined set of provid-  
21       ers.

22              “(J) RESTRICTIONS ON COVERAGE OF  
23       EMERGENCY SERVICES.—A description of the  
24       circumstances under which, and the extent to  
25       which, the coverage, in including emergency

1 medical care furnished to a participant or bene-  
2 ficiary of the plan imposes any financial respon-  
3 sibility described in subsection (c) on partici-  
4 pants or beneficiaries or limits or conditions  
5 benefits for such care subject to any other term  
6 or condition of such coverage.

7 “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
8 ITIES.—The information required under subsection (a) in-  
9 cludes an explanation of—

10 “(1) a participant’s financial responsibility for  
11 payment of premiums, coinsurance, copayments,  
12 deductibles, and any other charges; and

13 “(2) the circumstances under which, and the  
14 extent to which, the participant’s financial respon-  
15 sibility described in paragraph (1) may vary, includ-  
16 ing any distinctions based on whether a health care  
17 provider from whom covered benefits are obtained is  
18 included in a defined set of providers.

19 “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
20 formation required under subsection (a) includes a de-  
21 scription of the processes adopted in connection with such  
22 coverage pursuant to section 503(b) of the Employee Re-  
23 tirement Income Security Act of 1974, including—

24 “(1) descriptions thereof relating specifically  
25 to—



1 “(A) coverage decisions;

2 “(B) internal review of coverage decisions;

3 and

4 “(C) any external review of coverage deci-  
5 sions; and

6 “(2) the procedures and time frames applicable  
7 to each step of the processes referred to in subpara-  
8 graphs (A), (B), and (C) of paragraph (1).

9 “(e) INFORMATION AVAILABLE ON REQUEST.—

10 “(1) ACCESS TO PLAN BENEFIT INFORMATION  
11 IN ELECTRONIC FORM.—

12 “(A) IN GENERAL.—A group health plan  
13 (and a health insurance issuer offering health  
14 insurance coverage in connection with a group  
15 health plan) shall, upon written request (made  
16 not more frequently than annually), make avail-  
17 able to participants and beneficiaries, in a gen-  
18 erally recognized electronic format, the follow-  
19 ing information:

20 “(i) the latest summary plan descrip-  
21 tion, including the latest summary of ma-  
22 terial modifications; and

23 “(ii) the actual plan provisions setting  
24 forth the benefits available under the plan,

1 to the extent such information relates to the  
2 coverage options under the plan available to the  
3 participant or beneficiary. A reasonable charge  
4 may be made to cover the cost of providing  
5 such information in such generally recognized  
6 electronic format. The Secretary may by regula-  
7 tion prescribe a maximum amount which will  
8 constitute a reasonable charge under the pre-  
9 ceding sentence.

10 “(B) ALTERNATIVE ACCESS.—The require-  
11 ments of this paragraph may be met by making  
12 such information generally available (rather  
13 than upon request) on the Internet or on a pro-  
14 prietary computer network in a format which is  
15 readily accessible to participants and bene-  
16 ficiaries.

17 “(2) ADDITIONAL INFORMATION TO BE PRO-  
18 VIDED ON REQUEST.—

19 “(A) INCLUSION IN SUMMARY PLAN DE-  
20 SCRPTION OF SUMMARY OF ADDITIONAL IN-  
21 FORMATION.—The information required under  
22 subsection (a) includes a summary description  
23 of the types of information required by this  
24 subsection to be made available to participants  
25 and beneficiaries on request.

1           “(B) INFORMATION REQUIRED FROM  
2           PLANS AND ISSUERS ON REQUEST.—In addition  
3           to information required to be included in sum-  
4           mary plan descriptions under this subsection, a  
5           group health plan (and a health insurance  
6           issuer offering health insurance coverage in  
7           connection with a group health plan) shall pro-  
8           vide the following information to a participant  
9           or beneficiary on request:

10           “(i) NETWORK CHARACTERISTICS.—If  
11           the plan (or issuer) utilizes a defined set of  
12           providers under contract with the plan (or  
13           issuer), a detailed list of the names of such  
14           providers and their geographic location, set  
15           forth separately with respect to primary  
16           care providers and with respect to special-  
17           ists.

18           “(ii) CARE MANAGEMENT INFORMA-  
19           TION.—A description of the circumstances  
20           under which, and the extent to which, the  
21           plan has special disease management pro-  
22           grams or programs for persons with dis-  
23           abilities, indicating whether these pro-  
24           grams are voluntary or mandatory and  
25           whether a significant benefit differential

1 results from participation in such pro-  
2 grams.

3 “(iii) INCLUSION OF DRUGS AND  
4 BIOLOGICALS IN FORMULARIES.—A state-  
5 ment of whether a specific drug or biologi-  
6 cal is included in a formulary used to de-  
7 termine benefits under the plan and a de-  
8 scription of the procedures for considering  
9 requests for any patient-specific waivers.

10 “(iv) PROCEDURES FOR DETERMINING  
11 EXCLUSIONS BASED ON MEDICAL NECES-  
12 SITY OR EXPERIMENTAL TREATMENTS.—  
13 Upon receipt by the participant or bene-  
14 ficiary of any notification of an adverse  
15 coverage decision based on a determination  
16 relating to medical necessity or an experi-  
17 mental treatment or technology, a descrip-  
18 tion of the procedures and medically-based  
19 criteria used in such decision.

20 “(v) PREAUTHORIZATION AND UTILI-  
21 ZATION REVIEW PROCEDURES.—Upon re-  
22 ceipt by the participant or beneficiary of  
23 any notification of an adverse coverage de-  
24 cision, a description of the basis on which  
25 any preauthorization requirement or any

1 utilization review requirement has resulted  
2 in such decision.

3 “(vi) ACCREDITATION STATUS OF  
4 HEALTH INSURANCE ISSUERS AND SERV-  
5 ICE PROVIDERS.—A description of the ac-  
6 creditation and licencing status (if any) of  
7 each health insurance issuer offering  
8 health insurance coverage in connection  
9 with the plan and of any utilization review  
10 organization utilized by the issuer or the  
11 plan, together with the name and address  
12 of the accrediting or licencing authority.

13 “(vii) MEASURES OF ENROLLEE SAT-  
14 ISFACTION.—The latest information (if  
15 any) maintained by the plan, or by any  
16 health insurance issuer offering health in-  
17 surance coverage in connection with the  
18 plan, relating to enrollee satisfaction.

19 “(viii) QUALITY PERFORMANCE MEAS-  
20 URES.—The latest information (if any)  
21 maintained by the plan, or by any health  
22 insurance issuer offering health insurance  
23 coverage in connection with the plan, relat-  
24 ing to quality of performance of the deliv-  
25 ery of medical care with respect to cov-

1 erage options offered under the plan and  
2 of health care professionals and facilities  
3 providing medical care under the plan.

4 “(ix) INFORMATION RELATING TO EX-  
5 TERNAL REVIEWS.—The number of exter-  
6 nal reviews under section 503(b)(4) of the  
7 Employee Retirement Income Security Act  
8 of 1974 that have been completed during  
9 the prior plan year and the number of such  
10 reviews in which the recommendation re-  
11 ported under section 503(b)(4)(C)(iii) of  
12 such Act includes a recommendation for  
13 modification or reversal of an internal re-  
14 view decision under the plan.

15 “(C) INFORMATION REQUIRED FROM  
16 HEALTH CARE PROFESSIONALS ON REQUEST.—  
17 Any health care professional treating a partici-  
18 pant or beneficiary under a group health plan  
19 shall provide to the participant or beneficiary,  
20 on request, a description of his or her profes-  
21 sional qualifications (including board certifi-  
22 cation status, licensing status, and accreditation  
23 status, if any), privileges, and experience and a  
24 general description by category (including sal-  
25 ary, fee-for-service, capitation, and such other

1 categories as may be specified in regulations of  
2 the Secretary) of the applicable method by  
3 which such professional is compensated in con-  
4 nection with the provision of such medical care.

5 “(D) INFORMATION REQUIRED FROM  
6 HEALTH CARE FACILITIES ON REQUEST.—Any  
7 health care facility from which a participant or  
8 beneficiary has sought treatment under a group  
9 health plan shall provide to the participant or  
10 beneficiary, on request, a description of the fa-  
11 cility’s corporate form or other organizational  
12 form and all forms of licensing and accredita-  
13 tion status (if any) assigned to the facility by  
14 standard-setting organizations.

15 “(f) ACCESS TO INFORMATION RELEVANT TO THE  
16 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
17 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to  
18 information otherwise required to be made available under  
19 this section, a group health plan (and a health insurance  
20 issuer offering health insurance coverage in connection  
21 with a group health plan) shall, upon written request  
22 (made not more frequently than annually), make available  
23 to a participant (and an employee who, under the terms  
24 of the plan, is eligible for coverage but not enrolled) in  
25 connection with a period of enrollment the summary plan

1 description for any coverage option under the plan under  
2 which the participant is eligible to enroll and any informa-  
3 tion described in clauses (i), (ii), (iii), (vi), (vii), and (viii)  
4 of subsection (e)(2)(B).

5 “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
6 FORMULARIES.—Not later than 30 days before the effec-  
7 tive of date of any exclusion of a specific drug or biological  
8 from any drug formulary under the plan that is used in  
9 the treatment of a chronic illness or disease, the plan shall  
10 take such actions as are necessary to reasonably ensure  
11 that plan participants are informed of such exclusion. The  
12 requirements of this subsection may be satisfied—

13 “(1) by inclusion of information in publications  
14 broadly distributed by plan sponsors, employers, or  
15 employee organizations;

16 “(2) by electronic means of communication (in-  
17 cluding the Internet or proprietary computer net-  
18 works in a format which is readily accessible to par-  
19 ticipants);

20 “(3) by timely informing participants who,  
21 under an ongoing program maintained under the  
22 plan, have submitted their names for such notifica-  
23 tion; or

24 “(4) by any other reasonable means of timely  
25 informing plan participants.”.



1 **SEC. 2102. EFFECTIVE DATE.**

2 (a) IN GENERAL.—The amendments made by this  
3 subtitle shall apply with respect to plan years beginning  
4 on or after January 1 of the second calendar year follow-  
5 ing the date of the enactment of this Act. The Secretary  
6 shall first issue all regulations necessary to carry out the  
7 amendments made by this subtitle before such date.

8 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
9 enforcement action shall be taken, pursuant to the amend-  
10 ments made by this subtitle, against a group health plan  
11 or health insurance issuer with respect to a violation of  
12 a requirement imposed by such amendments before the  
13 date of issuance of final regulations issued in connection  
14 with such requirement, if the plan or issuer has sought  
15 to comply in good faith with such requirement.

16 **Subtitle C—HealthMarts**

17 **SEC. 2201. SHORT TITLE OF SUBTITLE.**

18 This subtitle may be cited as the “Health Care Con-  
19 sumer Empowerment Act of 1998”.

20 **SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH**  
21 **HEALTHMARTS.**

22 (a) IN GENERAL.—The Public Health Service Act is  
23 amended by adding at the end the following new title:

1    **“TITLE XXVIII—HEALTHMARTS**

2    **“SEC. 2801. DEFINITION OF HEALTHMART.**

3       “(a) IN GENERAL.—For purposes of this title, the  
4 term ‘HealthMart’ means a legal entity that meets the fol-  
5 lowing requirements:

6           “(1) ORGANIZATION.—The HealthMart is a  
7 nonprofit organization operated under the direction  
8 of a board of directors which is composed of rep-  
9 resentatives of not fewer than 2 and in equal num-  
10 bers from each of the following:

11               “(A) Small employers.

12               “(B) Employees of small employers.

13               “(C) Health care providers, which may be  
14 physicians, other health care professionals,  
15 health care facilities, or any combination there-  
16 of.

17               “(D) Entities, such as insurance compa-  
18 nies, health maintenance organizations, and li-  
19 censed provider-sponsored organizations, that  
20 underwrite or administer health benefits cov-  
21 erage.

22           “(2) OFFERING HEALTH BENEFITS COV-  
23 ERAGE.—

24               “(A) IN GENERAL.—The HealthMart, in  
25 conjunction with those health insurance issuers

1 that offer health benefits coverage through the  
2 HealthMart, makes available health benefits  
3 coverage in the manner described in subsection  
4 (b) to all small employers and eligible employees  
5 in the manner described in subsection (c)(2) at  
6 rates (including employer's and employee's  
7 share) that are established by the health insur-  
8 ance issuer on a policy or product specific basis  
9 and that may vary only as permissible under  
10 State law. A HealthMart is deemed to be a  
11 group health plan for purposes of applying sec-  
12 tion 702 of the Employee Retirement Income  
13 Security Act of 1974, section 2702 of this Act,  
14 and section 9802(b) of the Internal Revenue  
15 Code of 1986 (which limit variation among  
16 similarly situated individuals of required pre-  
17 miums for health benefits coverage on the basis  
18 of health status-related factors).

19 “(B) NONDISCRIMINATION IN COVERAGE  
20 OFFERED.—

21 “(i) IN GENERAL.—Subject to clause  
22 (ii), the HealthMart may not offer health  
23 benefits coverage to an eligible employee in  
24 a geographic area (as specified under para-  
25 graph (3)(A)) unless the same coverage is

1           offered to all such employees in the same  
2           geographic area. Section 2711(a)(1)(B) of  
3           this Act limits denial of enrollment of cer-  
4           tain eligible individuals under health bene-  
5           fits coverage in the small group market.

6           “(ii) CONSTRUCTION.—Nothing in  
7           this title shall be construed as requiring or  
8           permitting a health insurance issuer to  
9           provide coverage outside the service area of  
10          the issuer, as approved under State law.

11          “(C) NO FINANCIAL UNDERWRITING.—The  
12          HealthMart provides health benefits coverage  
13          only through contracts with health insurance  
14          issuers and does not assume insurance risk with  
15          respect to such coverage.

16          “(D) MINIMUM COVERAGE.—By the end of  
17          the first year of its operation and thereafter,  
18          the HealthMart maintains not fewer than 10  
19          purchasers and 100 members.

20          “(3) GEOGRAPHIC AREAS.—

21          “(A) SPECIFICATION OF GEOGRAPHIC  
22          AREAS.—The HealthMart shall specify the geo-  
23          graphic area (or areas) in which it makes avail-  
24          able health benefits coverage offered by health  
25          insurance issuers to small employers. Such an

1 area shall encompass at least one entire county  
2 or equivalent area.

3 “(B) MULTISTATE AREAS.—In the case of  
4 a HealthMart that serves more than one State,  
5 such geographic areas may be areas that in-  
6 clude portions of two or more contiguous  
7 States.

8 “(C) MULTIPLE HEALTHMARTS PER-  
9 MITTED IN SINGLE GEOGRAPHIC AREA.—Noth-  
10 ing in this title shall be construed as preventing  
11 the establishment and operation of more than  
12 one HealthMart in a geographic area or as lim-  
13 iting the number of HealthMarts that may op-  
14 erate in any area.

15 “(4) PROVISION OF ADMINISTRATIVE SERVICES  
16 TO PURCHASERS.—

17 “(A) IN GENERAL.—The HealthMart pro-  
18 vides administrative services for purchasers.  
19 Such services may include accounting, billing,  
20 enrollment information, and employee coverage  
21 status reports.

22 “(B) CONSTRUCTION.—Nothing in this  
23 subsection shall be construed as preventing a  
24 HealthMart from serving as an administrative  
25 service organization to any entity.

1           “(5) DISSEMINATION OF INFORMATION.—The  
2       HealthMart collects and disseminates (or arranges  
3       for the collection and dissemination of) consumer-  
4       oriented information on the scope, cost, and enrollee  
5       satisfaction of all coverage options offered through  
6       the HealthMart to its members and eligible individ-  
7       uals. Such information shall be defined by the  
8       HealthMart and shall be in a manner appropriate to  
9       the type of coverage offered. To the extent prac-  
10      ticable, such information shall include information  
11      on provider performance, locations and hours of op-  
12      eration of providers, outcomes, and similar matters.  
13      Nothing in this section shall be construed as pre-  
14      venting the dissemination of such information or  
15      other information by the HealthMart or by health  
16      insurance issuers through electronic or other means.

17           “(6)           FILING           INFORMATION.—The  
18      HealthMart—

19           “(A) files with the applicable Federal au-  
20           thority information that demonstrates the  
21           HealthMart’s compliance with the applicable re-  
22           quirements of this title; or

23           “(B) in accordance with rules established  
24           under section 2803(a), files with a State such

1 information as the State may require to dem-  
2 onstrate such compliance.

3 “(b) HEALTH BENEFITS COVERAGE REQUIRE-  
4 MENTS.—

5 “(1) COMPLIANCE WITH CONSUMER PROTEC-  
6 TION REQUIREMENTS.—Any health benefits coverage  
7 offered through a HealthMart shall—

8 “(A) be underwritten by a health insurance  
9 issuer that—

10 “(i) is licensed (or otherwise regu-  
11 lated) under State law (or is a community  
12 health organization that is offering health  
13 insurance coverage pursuant to section  
14 330B(a));

15 “(ii) meets all applicable State stand-  
16 ards relating to consumer protection, sub-  
17 ject to section 2802(b); and

18 “(iii) offers the coverage under a con-  
19 tract with the HealthMart;

20 “(B) subject to paragraph (2), be approved  
21 or otherwise permitted to be offered under  
22 State law; and

23 “(C) provide full portability of creditable  
24 coverage for individuals who remain members of  
25 the same HealthMart notwithstanding that they

1 change the employer through which they are  
2 members in accordance with the provisions of  
3 the parts 6 and 7 of subtitle B of title I of the  
4 Employee Retirement Income Security Act of  
5 1974 and titles XXII and XXVII of this Act,  
6 so long as both employers are purchasers in the  
7 HealthMart.

8 “(2) ALTERNATIVE PROCESS FOR APPROVAL OF  
9 HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMI-  
10 NATION OR DELAY.—

11 “(A) IN GENERAL.—The requirement of  
12 paragraph (1)(B) shall not apply to a policy or  
13 product of health benefits coverage offered in a  
14 State if the health insurance issuer seeking to  
15 offer such policy or product files an application  
16 to waive such requirement with the applicable  
17 Federal authority, and the authority deter-  
18 mines, based on the application and other evi-  
19 dence presented to the authority, that—

20 “(i) either (or both) of the grounds  
21 described in subparagraph (B) for approval  
22 of the application has been met; and

23 “(ii) the coverage meets the applicable  
24 State standards (other than those that  
25 have been preempted under section 2802).



1           “(B) GROUNDS.—The grounds described  
2           in this subparagraph with respect to a policy or  
3           product of health benefits coverage are as fol-  
4           lows:

5                   “(i) FAILURE TO ACT ON POLICY,  
6                   PRODUCT, OR RATE APPLICATION ON A  
7                   TIMELY BASIS.—The State has failed to  
8                   complete action on the policy or product  
9                   (or rates for the policy or product) within  
10                  90 days of the date of the State’s receipt  
11                  of a substantially complete application. No  
12                  period before the date of the enactment of  
13                  this section shall be included in determin-  
14                  ing such 90-day period.

15                  “(ii) DENIAL OF APPLICATION BASED  
16                  ON DISCRIMINATORY TREATMENT.—The  
17                  State has denied such an application  
18                  and—

19                   “(I) the standards or review  
20                   process imposed by the State as a  
21                   condition of approval of the policy or  
22                   product imposes either any material  
23                   requirements, procedures, or stand-  
24                   ards to such policy or product that  
25                   are not generally applicable to other

1 policies and products offered or any  
2 requirements that are preempted  
3 under section 2802; or

4 “(II) the State requires the  
5 issuer, as a condition of approval of  
6 the policy or product, to offer any pol-  
7 icy or product other than such policy  
8 or product.

9 “(C) ENFORCEMENT.—In the case of a  
10 waiver granted under subparagraph (A) to an  
11 issuer with respect to a State, the Secretary  
12 may enter into an agreement with the State  
13 under which the State agrees to provide for  
14 monitoring and enforcement activities with re-  
15 spect to compliance of such an issuer and its  
16 health insurance coverage with the applicable  
17 State standards described in subparagraph  
18 (A)(ii). Such monitoring and enforcement shall  
19 be conducted by the State in the same manner  
20 as the State enforces such standards with re-  
21 spect to other health insurance issuers and  
22 plans, without discrimination based on the type  
23 of issuer to which the standards apply. Such an  
24 agreement shall specify or establish mechanisms  
25 by which compliance activities are undertaken,

1 while not lengthening the time required to re-  
2 view and process applications for waivers under  
3 subparagraph (A).

4 “(3) EXAMPLES OF TYPES OF COVERAGE.—The  
5 health benefits coverage made available through a  
6 HealthMart may include, but is not limited to, any  
7 of the following if it meets the other applicable re-  
8 quirements of this title:

9 “(A) Coverage through a health mainte-  
10 nance organization.

11 “(B) Coverage in connection with a pre-  
12 ferred provider organization.

13 “(C) Coverage in connection with a li-  
14 censed provider-sponsored organization.

15 “(D) Indemnity coverage through an insur-  
16 ance company.

17 “(E) Coverage offered in connection with a  
18 contribution into a medical savings account or  
19 flexible spending account.

20 “(F) Coverage that includes a point-of-  
21 service option.

22 “(G) Coverage offered by a community  
23 health organization (as defined in section  
24 330B(e)).

1           “(H) Any combination of such types of  
2           coverage.

3           “(4) WELLNESS BONUSES FOR HEALTH PRO-  
4           MOTION.—Nothing in this title shall be construed as  
5           precluding a health insurance issuer offering health  
6           benefits coverage through a HealthMart from estab-  
7           lishing premium discounts or rebates for members or  
8           from modifying otherwise applicable copayments or  
9           deductibles in return for adherence to programs of  
10          health promotion and disease prevention so long as  
11          such programs are agreed to in advance by the  
12          HealthMart and comply with all other provisions of  
13          this title and do not discriminate among similarly  
14          situated members.

15          “(c) PURCHASERS; MEMBERS; HEALTH INSURANCE  
16          ISSUERS.—

17               “(1) PURCHASERS.—

18                   “(A) IN GENERAL.—Subject to the provi-  
19                   sions of this title, a HealthMart shall permit  
20                   any small employer to contract with the  
21                   HealthMart for the purchase of health benefits  
22                   coverage for its employees and dependents of  
23                   those employees and may not vary conditions of  
24                   eligibility (including premium rates and mem-

1           bership fees) of a small employer to be a pur-  
2           chaser.

3           “(B) ROLE OF ASSOCIATIONS, BROKERS,  
4           AND LICENSED HEALTH INSURANCE AGENTS.—  
5           Nothing in this section shall be construed as  
6           preventing an association, broker, licensed  
7           health insurance agent, or other entity from as-  
8           sisting or representing a HealthMart or small  
9           employers from entering into appropriate ar-  
10          rangements to carry out this title.

11          “(C) PERIOD OF CONTRACT.—The  
12          HealthMart may not require a contract under  
13          subparagraph (A) between a HealthMart and a  
14          purchaser to be effective for a period of longer  
15          than 12 months. The previous sentence shall  
16          not be construed as preventing such a contract  
17          from being extended for additional 12-month  
18          periods or preventing the purchaser from volun-  
19          tarily electing a contract period of longer than  
20          12 months.

21          “(D) EXCLUSIVE NATURE OF CON-  
22          TRACT.—Such a contract shall provide that the  
23          purchaser agrees not to obtain or sponsor  
24          health benefits coverage, on behalf of any eligi-  
25          ble employees (and their dependents), other

1           than through the HealthMart. The previous  
2           sentence shall not apply to an eligible individual  
3           who resides in an area for which no coverage is  
4           offered by any health insurance issuer through  
5           the HealthMart.

6           “(2) MEMBERS.—

7                 “(A) IN GENERAL.—Under rules estab-  
8                 lished to carry out this title, with respect to a  
9                 small employer that has a purchaser contract  
10                with a HealthMart, individuals who are employ-  
11                ees of the employer may enroll for health bene-  
12                fits coverage (including coverage for dependents  
13                of such enrolling employees) offered by a health  
14                insurance issuer through the HealthMart.

15               “(B) NONDISCRIMINATION IN ENROLL-  
16                MENT.—A HealthMart may not deny enroll-  
17                ment as a member to an individual who is an  
18                employee (or dependent of such an employee)  
19                eligible to be so enrolled based on health status-  
20                related factors, except as may be permitted con-  
21                sistent with section 2742(b).

22               “(C) ANNUAL OPEN ENROLLMENT PE-  
23                RIOD.—In the case of members enrolled in  
24                health benefits coverage offered by a health in-  
25                surance issuer through a HealthMart, subject

1 to subparagraph (D), the HealthMart shall pro-  
2 vide for an annual open enrollment period of 30  
3 days during which such members may change  
4 the coverage option in which the members are  
5 enrolled.

6 “(D) RULES OF ELIGIBILITY.—Nothing in  
7 this paragraph shall preclude a HealthMart  
8 from establishing rules of employee eligibility  
9 for enrollment and reenrollment of members  
10 during the annual open enrollment period under  
11 subparagraph (C). Such rules shall be applied  
12 consistently to all purchasers and members  
13 within the HealthMart and shall not be based  
14 in any manner on health status-related factors  
15 and may not conflict with sections 2701 and  
16 2702 of this Act.

17 “(3) HEALTH INSURANCE ISSUERS.—

18 “(A) PREMIUM COLLECTION.—The con-  
19 tract between a HealthMart and a health insur-  
20 ance issuer shall provide, with respect to a  
21 member enrolled with health benefits coverage  
22 offered by the issuer through the HealthMart,  
23 for the payment of the premiums collected by  
24 the HealthMart (or the issuer) for such cov-  
25 erage (less a pre-determined administrative

1 charge negotiated by the HealthMart and the  
2 issuer) to the issuer.

3 “(B) SCOPE OF SERVICE AREA.—Nothing  
4 in this title shall be construed as requiring the  
5 service area of a health insurance issuer with  
6 respect to health insurance coverage to cover  
7 the entire geographic area served by a  
8 HealthMart.

9 “(C) AVAILABILITY OF COVERAGE OP-  
10 TIONS.—A HealthMart shall enter into con-  
11 tracts with one or more health insurance issuers  
12 in a manner that assures that at least 2 health  
13 insurance coverage options are made available  
14 in the geographic area specified under sub-  
15 section (a)(3)(A).

16 “(d) PREVENTION OF CONFLICTS OF INTEREST.—

17 “(1) FOR BOARDS OF DIRECTORS.—A member  
18 of a board of directors of a HealthMart may not  
19 serve as an employee or paid consultant to the  
20 HealthMart, but may receive reasonable reimburse-  
21 ment for travel expenses for purposes of attending  
22 meetings of the board or committees thereof.

23 “(2) FOR BOARDS OF DIRECTORS OR EMPLOY-  
24 EES.—An individual is not eligible to serve in a paid  
25 or unpaid capacity on the board of directors of a



1 HealthMart or as an employee of the HealthMart, if  
2 the individual is employed by, represents in any ca-  
3 pacity, owns, or controls any ownership interest in  
4 a organization from whom the HealthMart receives  
5 contributions, grants, or other funds not connected  
6 with a contract for coverage through the  
7 HealthMart.

8 “(3) EMPLOYMENT AND EMPLOYEE REP-  
9 RESENTATIVES.—

10 “(A) IN GENERAL.—An individual who is  
11 serving on a board of directors of a HealthMart  
12 as a representative described in subparagraph  
13 (A) or (B) of section 2801(a)(1) shall not be  
14 employed by or affiliated with a health insur-  
15 ance issuer or be licensed as or employed by or  
16 affiliated with a health care provider.

17 “(B) CONSTRUCTION.—For purposes of  
18 subparagraph (A), the term “affiliated” does  
19 not include membership in a health benefits  
20 plan or the obtaining of health benefits cov-  
21 erage offered by a health insurance issuer.

22 “(e) CONSTRUCTION.—

23 “(1) NETWORK OF AFFILIATED  
24 HEALTHMARTS.—Nothing in this section shall be  
25 construed as preventing one or more HealthMarts

1 serving different areas (whether or not contiguous)  
2 from providing for some or all of the following  
3 (through a single administrative organization or oth-  
4 erwise):

5 “(A) Coordinating the offering of the same  
6 or similar health benefits coverage in different  
7 areas served by the different HealthMarts.

8 “(B) Providing for crediting of deductibles  
9 and other cost-sharing for individuals who are  
10 provided health benefits coverage through the  
11 HealthMarts (or affiliated HealthMarts)  
12 after—

13 “(i) a change of employers through  
14 which the coverage is provided; or

15 “(ii) a change in place of employment  
16 to an area not served by the previous  
17 HealthMart.

18 “(2) PERMITTING HEALTHMARTS TO ADJUST  
19 DISTRIBUTIONS AMONG ISSUERS TO REFLECT REL-  
20 ATIVE RISK OF ENROLLEES.—Nothing in this sec-  
21 tion shall be construed as precluding a HealthMart  
22 from providing for adjustments in amounts distrib-  
23 uted among the health insurance issuers offering  
24 health benefits coverage through the HealthMart  
25 based on factors such as the relative health care risk

1 of members enrolled under the coverage offered by  
2 the different issuers.

3 “(3) APPLICATION OF UNIFORM MINIMUM PAR-  
4 TICIPATION AND CONTRIBUTION RULES.—Nothing  
5 in this section shall be construed as precluding a  
6 HealthMart from establishing minimum participa-  
7 tion and contribution rules (described in section  
8 2711(e)(1)) for small employers that apply to be-  
9 come purchasers in the HealthMart, so long as such  
10 rules are applied uniformly for all health insurance  
11 issuers.

12 **“SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIRE-**  
13 **MENTS.**

14 “(a) AUTHORITY OF STATES.—Nothing in this sec-  
15 tion shall be construed as preempting State laws relating  
16 to the following:

17 “(1) The regulation of underwriters of health  
18 coverage, including licensure and solvency require-  
19 ments.

20 “(2) The application of premium taxes and re-  
21 quired payments for guaranty funds or for contribu-  
22 tions to high-risk pools.

23 “(3) The application of fair marketing require-  
24 ments and other consumer protections (other than

1       those specifically relating to an item described in  
2       subsection (b)).

3               “(4) The application of requirements relating to  
4       the adjustment of rates for health insurance cov-  
5       erage.

6       “(b) TREATMENT OF BENEFIT AND GROUPING RE-  
7       QUIREMENTS.—State laws insofar as they relate to any  
8       of the following are superseded and shall not apply to  
9       health benefits coverage made available through a  
10      HealthMart:

11              “(1) Benefit requirements for health benefits  
12       coverage offered through a HealthMart, including  
13       (but not limited to) requirements relating to cov-  
14       erage of specific providers, specific services or condi-  
15       tions, or the amount, duration, or scope of benefits,  
16       but not including requirements to the extent re-  
17       quired to implement title XXVII or other Federal  
18       law and to the extent the requirement prohibits an  
19       exclusion of a specific disease from such coverage.

20              “(2) Requirements (commonly referred to as  
21       fictitious group laws) relating to grouping and simi-  
22       lar requirements for such coverage to the extent  
23       such requirements impede the establishment and op-  
24       eration of HealthMarts pursuant to this title.

1           “(3) Any other requirements (including limita-  
2           tions on compensation arrangements) that, directly  
3           or indirectly, preclude (or have the effect of preclud-  
4           ing) the offering of such coverage through a  
5           HealthMart, if the HealthMart meets the require-  
6           ments of this title.

7 Any State law or regulation relating to the composition  
8 or organization of a HealthMart is preempted to the ex-  
9 tent the law or regulation is inconsistent with the provi-  
10 sions of this title.

11       “(c) APPLICATION OF ERISA FIDUCIARY AND DIS-  
12 CLOSURE REQUIREMENTS.—The board of directors of a  
13 HealthMart is deemed to be a plan administrator of an  
14 employee welfare benefit plan which is a group health plan  
15 for purposes of applying parts 1 and 4 of subtitle B of  
16 title I of the Employee Retirement Income Security Act  
17 of 1974 and those provisions of part 5 of such subtitle  
18 which are applicable to enforcement of such parts 1 and  
19 4, and the HealthMart shall be treated as such a plan  
20 and the enrollees shall be treated as participants and bene-  
21 ficiaries for purposes of applying such provisions pursuant  
22 to this subsection.

23       “(d) APPLICATION OF ERISA RENEWABILITY PRO-  
24 TECTION.—A HealthMart is deemed to be group health  
25 plan that is a multiple employer welfare arrangement for

1 purposes of applying section 703 of the Employee Retirement  
2 Income Security Act of 1974.

3 “(e) APPLICATION OF RULES FOR NETWORK PLANS  
4 AND FINANCIAL CAPACITY.—The provisions of sub-  
5 sections (c) and (d) of section 2711 apply to health bene-  
6 fits coverage offered by a health insurance issuer through  
7 a HealthMart.

8 “(f) CONSTRUCTION RELATING TO OFFERING RE-  
9 QUIREMENT.—Nothing in section 2711(a) of this Act or  
10 703 of the Employee Retirement Income Security Act of  
11 1974 shall be construed as permitting the offering outside  
12 the HealthMart of health benefits coverage that is only  
13 made available through a HealthMart under this section  
14 because of the application of subsection (b).

15 “(g) APPLICATION TO GUARANTEED RENEWABILITY  
16 REQUIREMENTS IN CASE OF DISCONTINUATION OF AN  
17 ISSUER.—For purposes of applying section 2712 in the  
18 case of health insurance coverage offered by a health in-  
19 surance issuer through a HealthMart, if the contract be-  
20 tween the HealthMart and the issuer is terminated and  
21 the HealthMart continues to make available any health in-  
22 surance coverage after the date of such termination, the  
23 following rules apply:

24 “(1) RENEWABILITY.—The HealthMart shall  
25 fulfill the obligation under such section of the issuer

1       renewing and continuing in force coverage by offer-  
2       ing purchasers (and members and their dependents)  
3       all available health benefits coverage that would oth-  
4       erwise be available to similarly-situated purchasers  
5       and members from the remaining participating  
6       health insurance issuers in the same manner as  
7       would be required of issuers under section 2712(c).

8               “(2) APPLICATION OF ASSOCIATION RULES.—

9       The HealthMart shall be considered an association  
10      for purposes of applying section 2712(e).

11      “(h) CONSTRUCTION IN RELATION TO CERTAIN  
12      OTHER LAWS.—Nothing in this title shall be construed  
13      as modifying or affecting the applicability to HealthMarts  
14      or health benefits coverage offered by a health insurance  
15      issuer through a HealthMart of parts 6 and 7 of subtitle  
16      B of title I of the Employee Retirement Income Security  
17      Act of 1974 or titles XXII and XXVII of this Act.

18      **“SEC. 2803. ADMINISTRATION.**

19      “(a) IN GENERAL.—The applicable Federal authority  
20      shall administer this title through the division established  
21      under subsection (b) and is authorized to issue such regu-  
22      lations as may be required to carry out this title. Such  
23      regulations shall be subject to Congressional review under  
24      the provisions of chapter 8 of title 5, United States Code.  
25      The applicable Federal authority shall incorporate the

1 process of ‘deemed file and use’ with respect to the infor-  
2 mation filed under section 2801(a)(6)(A) and shall deter-  
3 mine whether information filed by a HealthMart dem-  
4 onstrates compliance with the applicable requirements of  
5 this title. Such authority shall exercise its authority under  
6 this title in a manner that fosters and promotes the devel-  
7 opment of HealthMarts in order to improve access to  
8 health care coverage and services.

9 “(b) ADMINISTRATION THROUGH HEALTH CARE  
10 MARKETPLACE DIVISION.—

11 “(1) IN GENERAL.—The applicable Federal au-  
12 thority shall carry out its duties under this title  
13 through a separate Health Care Marketplace Divi-  
14 sion, the sole duty of which (including the staff of  
15 which) shall be to administer this title.

16 “(2) ADDITIONAL DUTIES.—In addition to  
17 other responsibilities provided under this title, such  
18 Division is responsible for—

19 “(A) oversight of the operations of  
20 HealthMarts under this title; and

21 “(B) the periodic submittal to Congress of  
22 reports on the performance of HealthMarts  
23 under this title under subsection (c).

24 “(c) PERIODIC REPORTS.—The applicable Federal  
25 authority shall submit to Congress a report every 30



1 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

8 **“SEC. 2804. DEFINITIONS.**

9 “For purposes of this title:

10 “(1) **APPLICABLE FEDERAL AUTHORITY.**—The  
11 term ‘applicable Federal authority’ means the Secretary of Health and Human Services.

12  
13 “(2) **ELIGIBLE EMPLOYEE OR INDIVIDUAL.**—  
14 The term ‘eligible’ means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section  
15  
16 2801(c)(2) to enroll or be enrolled in health benefits  
17 coverage offered through the HealthMart.

18  
19 “(3) **EMPLOYER; EMPLOYEE; DEPENDENT.**—  
20 Except as the applicable Federal authority may otherwise provide, the terms ‘employer’, ‘employee’, and  
21  
22 ‘dependent’, as applied to health insurance coverage  
23 offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings  
24 applied to such terms with respect to such coverage  
25

1 under the laws of the State relating to such coverage  
2 and such an issuer.

3 “(4) HEALTH BENEFITS COVERAGE.—The term  
4 ‘health benefits coverage’ has the meaning given the  
5 term group health insurance coverage in section  
6 2791(b)(4).

7 “(5) HEALTH INSURANCE ISSUER.—The term  
8 ‘health insurance issuer’ has the meaning given such  
9 term in section 2791(b)(2) and includes a commu-  
10 nity health organization that is offering coverage  
11 pursuant to section 330B(a).

12 “(6) HEALTH STATUS-RELATED FACTOR.—The  
13 term ‘health status-related factor’ has the meaning  
14 given such term in section 2791(d)(9).

15 “(7) HEALTHMART.—The term ‘HealthMart’ is  
16 defined in section 2801(a).

17 “(8) MEMBER.—The term ‘member’ means,  
18 with respect to a HealthMart, an individual enrolled  
19 for health benefits coverage through the HealthMart  
20 under section 2801(c)(2).

21 “(9) PURCHASER.—The term ‘purchaser’  
22 means, with respect to a HealthMart, a small em-  
23 ployer that has contracted under section  
24 2801(c)(1)(A) with the HealthMart for the purchase  
25 of health benefits coverage.

1 “(10) SMALL EMPLOYER.—The term ‘small em-  
 2 ployer’ has the meaning given such term for pur-  
 3 poses of title XXVII.”.

4 (b) EFFECTIVE DATE.—The amendment made by  
 5 subsection (a) shall take effect on January 1, 2000. The  
 6 Secretary of Health and Human Services shall first issue  
 7 all regulations necessary to carry out such amendment be-  
 8 fore such date.

## 9 **Subtitle D—Community Health** 10 **Organizations**

### 11 **SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY** 12 **COMMUNITY HEALTH ORGANIZATIONS.**

13 (a) WAIVER OF STATE LICENSURE REQUIREMENT  
 14 FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN  
 15 CASES.—Subpart I of part D of title III of the Public  
 16 Health Service Act is amended by adding at the end the  
 17 following new section:

18 “WAIVER OF STATE LICENSURE REQUIREMENT FOR  
 19 COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

20 “SEC. 330B. (a) WAIVER AUTHORIZED.—

21 “(1) IN GENERAL.—A community health orga-  
 22 nization may offer health insurance coverage in a  
 23 State notwithstanding that it is not licensed in such  
 24 a State to offer such coverage if—

25 “(A) the organization files an application  
 26 for waiver of the licensure requirement with the

1 Secretary of Health and Human Services (in  
2 this section referred to as the ‘Secretary’) by  
3 not later than November 1, 2003; and

4 “(B) the Secretary determines, based on  
5 the application and other evidence presented to  
6 the Secretary, that any of the grounds for ap-  
7 proval of the application described in subpara-  
8 graph (A), (B), or (C) of paragraph (2) has  
9 been met.

10 “(2) GROUNDS FOR APPROVAL OF WAIVER.—

11 “(A) FAILURE TO ACT ON LICENSURE AP-  
12 PPLICATION ON A TIMELY BASIS.—The ground  
13 for approval of such a waiver application de-  
14 scribed in this subparagraph is that the State  
15 has failed to complete action on a licensing ap-  
16 plication of the organization within 90 days of  
17 the date of the State’s receipt of a substantially  
18 complete application. No period before the date  
19 of the enactment of this section shall be in-  
20 cluded in determining such 90-day period.

21 “(B) DENIAL OF APPLICATION BASED ON  
22 DISCRIMINATORY TREATMENT.—The ground for  
23 approval of such a waiver application described  
24 in this subparagraph is that the State has de-  
25 nied such a licensing application and the stand-

1       ards or review process imposed by the State as  
2       a condition of approval of the license or as the  
3       basis for such denial by the State imposes any  
4       material requirements, procedures, or standards  
5       (other than solvency requirements) to such or-  
6       ganizations that are not generally applicable to  
7       other entities engaged in a substantially similar  
8       business.

9               “(C) DENIAL OF APPLICATION BASED ON  
10       APPLICATION OF SOLVENCY REQUIREMENTS.—

11       With respect to waiver applications filed on or  
12       after the date of publication of solvency stand-  
13       ards established by the Secretary under sub-  
14       section (d), the ground for approval of such a  
15       waiver application described in this subpara-  
16       graph is that the State has denied such a li-  
17       censing application based (in whole or in part)  
18       on the organization’s failure to meet applicable  
19       State solvency requirements and such require-  
20       ments are not the same as the solvency stand-  
21       ards established by the Secretary. For purposes  
22       of this subparagraph, the term solvency require-  
23       ments means requirements relating to solvency  
24       and other matters covered under the standards

1 established by the Secretary under subsection  
2 (d).

3 “(3) TREATMENT OF WAIVER.—In the case of  
4 a waiver granted under this subsection for a commu-  
5 nity health organization with respect to a State—

6 “(A) LIMITATION TO STATE.—The waiver  
7 shall be effective only with respect to that State  
8 and does not apply to any other State.

9 “(B) LIMITATION TO 36-MONTH PERIOD.—  
10 The waiver shall be effective only for a 36-  
11 month period but may be renewed for up to 36  
12 additional months if the Secretary determines  
13 that such an extension is appropriate.

14 “(C) CONDITIONED ON COMPLIANCE WITH  
15 CONSUMER PROTECTION AND QUALITY STAND-  
16 ARDS.—The continuation of the waiver is condi-  
17 tioned upon the organization’s compliance with  
18 the requirements described in paragraph (5).

19 “(D) PREEMPTION OF STATE LAW.—Any  
20 provisions of law of that State which relate to  
21 the licensing of the organization and which pro-  
22 hibit the organization from providing health in-  
23 surance coverage shall be superseded.

24 “(4) PROMPT ACTION ON APPLICATION.—The  
25 Secretary shall grant or deny such a waiver applica-

tion within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization’s compliance with all consumer protection and quality standards insofar as such standards—

“(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

“(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

“(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver

1 process under this subsection should be continued  
2 after December 31, 2003.

3 “(b) ASSUMPTION OF FULL FINANCIAL RISK.—To  
4 qualify for a waiver under subsection (a), the community  
5 health organization shall assume full financial risk on a  
6 prospective basis for the provision of covered health care  
7 services, except that the organization—

8 “(1) may obtain insurance or make other ar-  
9 rangements for the cost of providing to any enrolled  
10 member such services the aggregate value of which  
11 exceeds such aggregate level as the Secretary speci-  
12 fies from time to time;

13 “(2) may obtain insurance or make other ar-  
14 rangements for the cost of such services provided to  
15 its enrolled members other than through the organi-  
16 zation because medical necessity required their pro-  
17 vision before they could be secured through the orga-  
18 nization;

19 “(3) may obtain insurance or make other ar-  
20 rangements for not more than 90 percent of the  
21 amount by which its costs for any of its fiscal years  
22 exceed 105 percent of its income for such fiscal year;  
23 and

24 “(4) may make arrangements with physicians  
25 or other health care professionals, health care insti-



1       tutions, or any combination of such individuals or  
2       institutions to assume all or part of the financial  
3       risk on a prospective basis for the provision of  
4       health services by the physicians or other health pro-  
5       fessionals or through the institutions.

6       “(c) CERTIFICATION OF PROVISION AGAINST RISK OF  
7       INSOLVENCY FOR UNLICENSED CHOs.—

8               “(1) IN GENERAL.—Each community health or-  
9       ganization that is not licensed by a State and for  
10      which a waiver application has been approved under  
11      subsection (a)(1), shall meet standards established  
12      by the Secretary under subsection (d) relating to the  
13      financial solvency and capital adequacy of the orga-  
14      nization.

15              “(2) CERTIFICATION PROCESS FOR SOLVENCY  
16      STANDARDS FOR CHOS.—The Secretary shall estab-  
17      lish a process for the receipt and approval of appli-  
18      cations of a community health organization de-  
19      scribed in paragraph (1) for certification (and peri-  
20      odic recertification) of the organization as meeting  
21      such solvency standards. Under such process, the  
22      Secretary shall act upon such a certification applica-  
23      tion not later than 60 days after the date the appli-  
24      cation has been received.

1       “(d) ESTABLISHMENT OF SOLVENCY STANDARDS  
2 FOR COMMUNITY HEALTH ORGANIZATIONS.—

3               “(1) IN GENERAL.—The Secretary shall estab-  
4 lish, on an expedited basis and by rule pursuant to  
5 section 553 of title 5, United States Code and  
6 through the Health Resources and Services Adminis-  
7 tration, standards described in subsection (c)(1) (re-  
8 lating to financial solvency and capital adequacy)  
9 that entities must meet to obtain a waiver under  
10 subsection (a)(2)(C). In establishing such standards,  
11 the Secretary shall consult with interested organiza-  
12 tions, including the National Association of Insur-  
13 ance Commissioners, the Academy of Actuaries, and  
14 organizations representing Federally qualified health  
15 centers.

16               “(2) FACTORS TO CONSIDER FOR SOLVENCY  
17 STANDARDS.—In establishing solvency standards for  
18 community health organizations under paragraph  
19 (1), the Secretary shall take into account—

20                       “(A) the delivery system assets of such an  
21 organization and ability of such an organization  
22 to provide services to enrollees;

23                       “(B) alternative means of protecting  
24 against insolvency, including reinsurance, unre-  
25 stricted surplus, letters of credit, guarantees,

1 organizational insurance coverage, partnerships  
2 with other licensed entities, and valuation at-  
3 tributable to the ability of such an organization  
4 to meet its service obligations through direct  
5 delivery of care; and

6 “(C) any standards developed by the Na-  
7 tional Association of Insurance Commissioners  
8 specifically for risk-based health care delivery  
9 organizations.

10 “(3) ENROLLEE PROTECTION AGAINST INSOL-  
11 VENCY.—Such standards shall include provisions to  
12 prevent enrollees from being held liable to any per-  
13 son or entity for the organization’s debts in the  
14 event of the organization’s insolvency.

15 “(4) DEADLINE.—Such standards shall be pro-  
16 mulgated in a manner so they are first effective by  
17 not later than April 1, 1999.

18 “(e) DEFINITIONS.—In this section:

19 “(1) COMMUNITY HEALTH ORGANIZATION.—  
20 The term ‘community health organization ’ means  
21 an organization that is a Federally-qualified health  
22 center or is controlled by one or more Federally-  
23 qualified health centers.

24 “(2) FEDERALLY-QUALIFIED HEALTH CEN-  
25 TER.—The term ‘Federally-qualified health center’

1 has the meaning given such term in section  
 2 1905(l)(2)(B) of the Social Security Act.

3 “(3) HEALTH INSURANCE COVERAGE.—The  
 4 term ‘health insurance coverage’ has the meaning  
 5 given such term in section 2791(b)(1).

6 “(4) CONTROL.—The term ‘control’ means the  
 7 possession, whether direct or indirect, of the power  
 8 to direct or cause the direction of the management  
 9 and policies of the organization through member-  
 10 ship, board representation, or an ownership interest  
 11 equal to or greater than 50.1 percent.”.

12 **TITLE III—AMENDMENTS TO**  
 13 **THE INTERNAL REVENUE**  
 14 **CODE OF 1986**

15 **Subtitle A—Patient Protections**

16 **SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
 17 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
 18 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
 19 **ATRIC CARE.**

20 (a) IN GENERAL.—Subchapter B of chapter 100 of  
 21 the Internal Revenue Code of 1986 (relating to other re-  
 22 quirements) is amended by adding at the end the following  
 23 new section:

1 **“SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL**  
2 **ADVICE, EMERGENCY MEDICAL CARE, OB-**  
3 **STETRIC AND GYNECOLOGICAL CARE, PEDI-**  
4 **ATRIC CARE.**

5 “(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL  
6 ADVICE.—

7 “(1) IN GENERAL.—In the case of any health  
8 care professional acting within the lawful scope of  
9 practice in the course of carrying out a contractual  
10 employment arrangement or other direct contractual  
11 arrangement between such professional and a group  
12 health plan, the plan with which such contractual  
13 employment arrangement or other direct contractual  
14 arrangement is maintained by the professional may  
15 not impose on such professional under such arrange-  
16 ment any prohibition or restriction with respect to  
17 advice, provided to a participant or beneficiary  
18 under the plan who is a patient, about the health  
19 status of the participant or beneficiary or the medi-  
20 cal care or treatment for the condition or disease of  
21 the participant or beneficiary, regardless of whether  
22 benefits for such care or treatment are provided  
23 under the plan.

24 “(2) HEALTH CARE PROFESSIONAL DEFINED.—  
25 For purposes of this subsection, the term ‘health  
26 care professional’ means a physician (as defined in

1 section 1861(r) of the Social Security Act) or other  
2 health care professional if coverage for the profes-  
3 sional's services is provided under the group health  
4 plan for the services of the professional. Such term  
5 includes a podiatrist, optometrist, chiropractor, psy-  
6 chologist, dentist, physician assistant, physical or oc-  
7 cupational therapist and therapy assistant, speech-  
8 language pathologist, audiologist, registered or li-  
9 censed practical nurse (including nurse practitioner,  
10 clinical nurse specialist, certified registered nurse  
11 anesthetist, and certified nurse-midwife), licensed  
12 certified social worker, registered respiratory thera-  
13 pist, and certified respiratory therapy technician.

14 “(b) PATIENT ACCESS TO EMERGENCY MEDICAL  
15 CARE.—

16 “(1) IN GENERAL.—To the extent that the  
17 group health plan provides for any benefits consist-  
18 ing of emergency medical care (as defined in section  
19 503(b)(9)(I) of the Employee Retirement Income Se-  
20 curity Act of 1974), except for items or services spe-  
21 cifically excluded—

22 “(A) the plan shall provide benefits, with-  
23 out requiring preauthorization and without re-  
24 gard to otherwise applicable network limita-  
25 tions, for appropriate emergency medical

1 screening examinations (within the capability of  
2 the emergency facility, including ancillary serv-  
3 ices routinely available to the emergency facil-  
4 ity) to the extent that a prudent layperson, who  
5 possesses an average knowledge of health and  
6 medicine, would determine such examinations to  
7 be necessary in order to determine whether  
8 emergency medical care (as so defined) is re-  
9 quired; and

10 “(B) the plan shall provide benefits for ad-  
11 ditional emergency medical services following an  
12 emergency medical screening examination (if  
13 determined necessary under subparagraph (A))  
14 to the extent that a prudent emergency medical  
15 professional would determine such additional  
16 emergency services to be necessary to avoid the  
17 consequences described in clause (i) of section  
18 503(b)(9)(I) of such Act.

19 “(2) UNIFORM COST-SHARING REQUIRED.—

20 Nothing in this subsection shall be construed as pre-  
21 venting a group health plan from imposing any form  
22 of cost-sharing applicable to any participant or bene-  
23 ficiary (including coinsurance, copayments,  
24 deductibles, and any other charges) in relation to  
25 benefits described in paragraph (1), if such form of

1 cost-sharing is uniformly applied under such plan,  
2 with respect to similarly situated participants and  
3 beneficiaries, to all benefits consisting of emergency  
4 medical care (as defined in section 503(b)(9)(I) of  
5 the Employee Retirement Income Security Act of  
6 1974) provided to such similarly situated partici-  
7 pants and beneficiaries under the plan.

8 “(c) PATIENT ACCESS TO OBSTETRIC AND GYNECO-  
9 LOGICAL CARE.—

10 “(1) IN GENERAL.—In any case in which a  
11 group health plan—

12 “(A) provides benefits under the terms of  
13 the plan consisting of—

14 “(i) routine gynecological care (such  
15 as preventive women’s health examina-  
16 tions); or

17 “(ii) routine obstetric care (such as  
18 routine pregnancy-related services),

19 provided by a participating physician who spe-  
20 cializes in such care (or provides benefits con-  
21 sisting of payment for such care); and

22 “(B) the plan requires or provides for des-  
23 ignation by a participant or beneficiary of a  
24 participating primary care provider,



1 if the primary care provider designated by such a  
2 participant or beneficiary is not such a physician,  
3 then the plan shall meet the requirements of para-  
4 graph (2).

5 “(2) REQUIREMENTS.—A group health plan  
6 meets the requirements of this paragraph, in connec-  
7 tion with benefits described in paragraph (1) con-  
8 sisting of care described in clause (i) or (ii) of para-  
9 graph (1)(A) (or consisting of payment therefor), if  
10 the plan—

11 “(A) does not require authorization or a  
12 referral by the primary care provider in order  
13 to obtain such benefits; and

14 “(B) treats the ordering of other routine  
15 care of the same type, by the participating phy-  
16 sician providing the care described in clause (i)  
17 or (ii) of paragraph (1)(A), as the authorization  
18 of the primary care provider with respect to  
19 such care.

20 “(3) CONSTRUCTION.—Nothing in paragraph  
21 (2)(B) shall waive any requirements of coverage re-  
22 lating to medical necessity or appropriateness with  
23 respect to coverage of gynecological or obstetric care  
24 so ordered.

25 “(d) PATIENT ACCESS TO PEDIATRIC CARE.—

1           “(1) IN GENERAL.—In any case in which a  
2           group health plan (or a health insurance issuer of-  
3           fering health insurance coverage in connection with  
4           the plan) provides benefits consisting of routine pe-  
5           diatric care provided by a participating physician  
6           who specializes in pediatrics (or consisting of pay-  
7           ment for such care) and the plan requires or pro-  
8           vides for designation by a participant or beneficiary  
9           of a participating primary care provider, the plan (or  
10          issuer) shall provide that such a participating physi-  
11          cian may be designated, if available, by a parent or  
12          guardian of any beneficiary under the plan is who  
13          under 18 years of age, as the primary care provider  
14          with respect to any such benefits.

15          “(2) CONSTRUCTION.—Nothing in paragraph  
16          (1) shall waive any requirements of coverage relating  
17          to medical necessity or appropriateness with respect  
18          to coverage of pediatric care.

19          “(e) TREATMENT OF MULTIPLE COVERAGE OP-  
20          TIONS.—In the case of a plan providing benefits under two  
21          or more coverage options, the requirements of subsections  
22          (c) and (d) shall apply separately with respect to each cov-  
23          erage option.”.

1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 of such subchapter of such chapter is amended by adding  
 3 at the end the following new item:

“Sec. 9813. Patient access to unrestricted medical advice, emer-  
 gency medical care, obstetric and gynecological  
 care, pediatric care.”.

4 **SEC. 3002. EFFECTIVE DATE AND RELATED RULES.**

5 (a) IN GENERAL.—The amendments made by this  
 6 subtitle shall apply with respect to plan years beginning  
 7 on or after January 1 of the second calendar year follow-  
 8 ing the date of the enactment of this Act, except that the  
 9 Secretary of the Treasury may issue regulations before  
 10 such date under such amendments. The Secretary shall  
 11 first issue regulations necessary to carry out the amend-  
 12 ments made by this section before the effective date there-  
 13 of.

14 (b) LIMITATION ON PENALTY FOR CERTAIN FAIL-  
 15 URES.—No penalty shall be imposed on any failure to  
 16 comply with any requirement imposed by the amendments  
 17 made by section 3101 to the extent such failure occurs  
 18 before the date of issuance of regulations issued in connec-  
 19 tion with such requirement if the plan has sought to com-  
 20 ply in good faith with such requirement.

21 (c) SPECIAL RULE FOR COLLECTIVE BARGAINING  
 22 AGREEMENTS.—In the case of a group health plan main-  
 23 tained pursuant to one or more collective bargaining  
 24 agreements between employee representatives and one or

1 more employers ratified before the date of the enactment  
 2 of this Act, the provisions of subsections (b), (c), and (d)  
 3 of section 9813 of the Internal Revenue Code of 1986 (as  
 4 added by this subtitle) shall not apply with respect to plan  
 5 years beginning before the later of—

6 (1) the date on which the last of the collective  
 7 bargaining agreements relating to the plan termi-  
 8 nates (determined without regard to any extension  
 9 thereof agreed to after the date of the enactment of  
 10 this Act); or

11 (2) January 1, 2001.

12 For purposes of this subsection, any plan amend-  
 13 ment made pursuant to a collective bargaining  
 14 agreement relating to the plan which amends the  
 15 plan solely to conform to any requirement added by  
 16 this subtitle shall not be treated as a termination of  
 17 such collective bargaining agreement.

## 18 **Subtitle B—Patient Access to** 19 **Information**

### 20 **SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING** 21 **PLAN COVERAGE, MANAGED CARE PROCE-** 22 **DURES, HEALTH CARE PROVIDERS, AND** 23 **QUALITY OF MEDICAL CARE.**

24 (a) IN GENERAL.—Subchapter B of chapter 100 of  
 25 the Internal Revenue Code of 1986 (relating to other re-

1 quirements) is amended by adding at the end the following  
2 new section:

3 **“SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.**

4       “(a) DISCLOSURE REQUIREMENT.—The adminis-  
5 trator of each group health plan shall take such actions  
6 as are necessary to ensure that the summary plan descrip-  
7 tion of the plan required under section 102 of Employee  
8 Retirement Income Security Act of 1974 (or each sum-  
9 mary plan description in any case in which different sum-  
10 mary plan descriptions are appropriate under part 1 of  
11 subtitle B of title I of such Act for different options of  
12 coverage) contains the information required under sub-  
13 sections (b), (c), (d), and (e)(2)(A). To the extent that  
14 any health insurance issuer offering health insurance cov-  
15 erage in connection with such plan provides such informa-  
16 tion on a timely basis to plan participants and bene-  
17 ficiaries, the requirements of this subsection shall be  
18 deemed satisfied in the case of such plan with respect to  
19 such information.

20       “(b) PLAN BENEFITS.—The information required  
21 under subsection (a) includes the following:

22               “(1) COVERED ITEMS AND SERVICES.—

23                       “(A) CATEGORIZATION OF INCLUDED BEN-  
24 EFITS.—A description of covered benefits, cat-  
25 egorized by—

1 “(i) types of items and services (in-  
2 cluding any special disease management  
3 program); and

4 “(ii) types of health care professionals  
5 providing such items and services.

6 “(B) EMERGENCY MEDICAL CARE.—A de-  
7 scription of the extent to which the plan covers  
8 emergency medical care (including the extent to  
9 which the plan provides for access to urgent  
10 care centers), and any definitions provided  
11 under the plan for the relevant plan terminol-  
12 ogy referring to such care.

13 “(C) PREVENTATIVE SERVICES.—A de-  
14 scription of the extent to which the plan pro-  
15 vides benefits for preventative services.

16 “(D) DRUG FORMULARIES.—A description  
17 of the extent to which covered benefits are de-  
18 termined by the use or application of a drug  
19 formulary and a summary of the process for de-  
20 termining what is included in such formulary.

21 “(E) COBRA CONTINUATION COV-  
22 ERAGE.—A description of the requirements  
23 under section 4980B.

24 “(2) LIMITATIONS, EXCLUSIONS, AND RESTRIC-  
25 TIONS ON COVERED BENEFITS.—

1           “(A) CATEGORIZATION OF EXCLUDED  
2 BENEFITS.—A description of benefits specifi-  
3 cally excluded from coverage, categorized by  
4 types of items and services.

5           “(B) UTILIZATION REVIEW AND  
6 PREAUTHORIZATION REQUIREMENTS.—Whether  
7 coverage for medical care is limited or excluded  
8 on the basis of utilization review or  
9 preauthorization requirements.

10          “(C) LIFETIME, ANNUAL, OR OTHER PE-  
11 RIOD LIMITATIONS.—A description of the cir-  
12 cumstances under which, and the extent to  
13 which, coverage is subject to lifetime, annual, or  
14 other period limitations, categorized by types of  
15 benefits.

16          “(D) CUSTODIAL CARE.—A description of  
17 the circumstances under which, and the extent  
18 to which, the coverage of benefits for custodial  
19 care is limited or excluded, and a statement of  
20 the definition used by the plan for custodial  
21 care.

22          “(E) EXPERIMENTAL TREATMENTS.—  
23 Whether coverage for any medical care is lim-  
24 ited or excluded because it constitutes experi-  
25 mental treatment or technology, and any defini-

1           tions provided under the plan for the relevant  
2           plan terminology referring to such limited or  
3           excluded care.

4           “(F) MEDICAL APPROPRIATENESS OR NE-  
5           CESSITY.—Whether coverage for medical care  
6           may be limited or excluded by reason of a fail-  
7           ure to meet the plan’s requirements for medical  
8           appropriateness or necessity, and any defini-  
9           tions provided under the plan for the relevant  
10          plan terminology referring to such limited or  
11          excluded care.

12          “(G) SECOND OR SUBSEQUENT OPIN-  
13          IONS.—A description of the circumstances  
14          under which, and the extent to which, coverage  
15          for second or subsequent opinions is limited or  
16          excluded.

17          “(H) SPECIALTY CARE.—A description of  
18          the circumstances under which, and the extent  
19          to which, coverage of benefits for specialty care  
20          is conditioned on referral from a primary care  
21          provider.

22          “(I) CONTINUITY OF CARE.—A description  
23          of the circumstances under which, and the ex-  
24          tent to which, coverage of items and services  
25          provided by any health care professional is lim-



1           ited or excluded by reason of the departure by  
2           the professional from any defined set of provid-  
3           ers.

4           “(J) RESTRICTIONS ON COVERAGE OF  
5           EMERGENCY SERVICES.—A description of the  
6           circumstances under which, and the extent to  
7           which, the plan, in covering emergency medical  
8           care furnished to a participant or beneficiary of  
9           the plan imposes any financial responsibility de-  
10          scribed in subsection (c) on participants or  
11          beneficiaries or limits or conditions benefits for  
12          such care subject to any other term or condition  
13          of such plan.

14          “(c) PARTICIPANT’S FINANCIAL RESPONSIBIL-  
15          ITIES.—The information required under subsection (a) in-  
16          cludes an explanation of—

17               “(1) a participant’s financial responsibility for  
18               payment of premiums, coinsurance, copayments,  
19               deductibles, and any other charges; and

20               “(2) the circumstances under which, and the  
21               extent to which, the participant’s financial respon-  
22               sibility described in paragraph (1) may vary, includ-  
23               ing any distinctions based on whether a health care  
24               provider from whom covered benefits are obtained is  
25               included in a defined set of providers.

1       “(d) DISPUTE RESOLUTION PROCEDURES.—The in-  
2 formation required under subsection (a) includes a de-  
3 scription of the processes adopted by the plan pursuant  
4 to section 503(b) of Employee Retirement Income Secu-  
5 rity Act of 1974, including—

6               “(1) descriptions thereof relating specifically  
7 to—

8                       “(A) coverage decisions;

9                       “(B) internal review of coverage decisions;

10                      and

11                      “(C) any external review of coverage deci-  
12 sions; and

13               “(2) the procedures and time frames applicable  
14 to each step of the processes referred to in subpara-  
15 graphs (A), (B), and (C) of paragraph (1).

16       “(e) INFORMATION AVAILABLE ON REQUEST.—

17               “(1) ACCESS TO PLAN BENEFIT INFORMATION  
18 IN ELECTRONIC FORM.—

19                      “(A) IN GENERAL.—A group health plan  
20 shall, upon written request (made not more fre-  
21 quently than annually), make available to par-  
22 ticipants and beneficiaries, in a generally recog-  
23 nized electronic format, the following informa-  
24 tion:

1                   “(i) the latest summary plan descrip-  
2                   tion, including the latest summary of ma-  
3                   terial modifications; and

4                   “(ii) the actual plan provisions setting  
5                   forth the benefits available under the plan  
6                   to the extent such information relates to the  
7                   coverage options under the plan available to the  
8                   participant or beneficiary. A reasonable charge  
9                   may be made to cover the cost of providing  
10                  such information in such generally recognized  
11                  electronic format. The Secretary may by regula-  
12                  tion prescribe a maximum amount which will  
13                  constitute a reasonable charge under the pre-  
14                  ceding sentence.

15                  “(B) ALTERNATIVE ACCESS.—The require-  
16                  ments of this paragraph may be met by making  
17                  such information generally available (rather  
18                  than upon request) on the Internet or on a pro-  
19                  prietary computer network in a format which is  
20                  readily accessible to participants and bene-  
21                  ficiaries.

22                  “(2) ADDITIONAL INFORMATION TO BE PRO-  
23                  VIDED ON REQUEST.—

24                  “(A) INCLUSION IN SUMMARY PLAN DE-  
25                  SCRIPTION OF SUMMARY OF ADDITIONAL IN-

1           FORMATION.—The information required under  
2           subsection (a) includes a summary description  
3           of the types of information required by this  
4           subsection to be made available to participants  
5           and beneficiaries on request.

6           “(B) INFORMATION REQUIRED FROM  
7           PLANS ON REQUEST.—In addition to informa-  
8           tion required to be included in summary plan  
9           descriptions under this subsection, a group  
10          health plan shall provide the following informa-  
11          tion to a participant or beneficiary on request:

12           “(i) NETWORK CHARACTERISTICS.—If  
13           the plan (or a health insurance issuer of-  
14           fering health insurance coverage in connec-  
15           tion with the plan) utilizes a defined set of  
16           providers under contract with the plan (or  
17           issuer), a detailed list of the names of such  
18           providers and their geographic location, set  
19           forth separately with respect to primary  
20           care providers and with respect to special-  
21           ists.

22           “(ii) CARE MANAGEMENT INFORMA-  
23           TION.—A description of the circumstances  
24           under which, and the extent to which, the  
25           plan has special disease management pro-

1           grams or programs for persons with dis-  
2           abilities, indicating whether these pro-  
3           grams are voluntary or mandatory and  
4           whether a significant benefit differential  
5           results from participation in such pro-  
6           grams.

7           “(iii) INCLUSION OF DRUGS AND  
8           BIOLOGICALS IN FORMULARIES.—A state-  
9           ment of whether a specific drug or biologi-  
10          cal is included in a formulary used to de-  
11          termine benefits under the plan and a de-  
12          scription of the procedures for considering  
13          requests for any patient-specific waivers.

14          “(iv) PROCEDURES FOR DETERMINING  
15          EXCLUSIONS BASED ON MEDICAL NECES-  
16          SITY OR EXPERIMENTAL TREATMENTS.—  
17          Upon receipt by the participant or bene-  
18          ficiary of any notification of an adverse  
19          coverage decision based on a determination  
20          relating to medical necessity or an experi-  
21          mental treatment or technology, a descrip-  
22          tion of the procedures and medically-based  
23          criteria used in such decision.

24          “(v) PREAUTHORIZATION AND UTILI-  
25          ZATION REVIEW PROCEDURES.—Upon re-

1 ceipt by the participant or beneficiary of  
2 any notification of an adverse coverage de-  
3 cision, a description of the basis on which  
4 any preauthorization requirement or any  
5 utilization review requirement has resulted  
6 in such decision.

7 “(vi) ACCREDITATION STATUS OF  
8 HEALTH INSURANCE ISSUERS AND SERV-  
9 ICE PROVIDERS.—A description of the ac-  
10 creditation and licencing status (if any) of  
11 each health insurance issuer offering  
12 health insurance coverage in connection  
13 with the plan and of any utilization review  
14 organization utilized by the issuer or the  
15 plan, together with the name and address  
16 of the accrediting or licencing authority.

17 “(vii) MEASURES OF ENROLLEE SAT-  
18 ISFACTION.—The latest information (if  
19 any) maintained by the plan, or by any  
20 health insurance issuer offering health in-  
21 surance coverage in connection with the  
22 plan, relating to enrollee satisfaction.

23 “(viii) QUALITY PERFORMANCE MEAS-  
24 URES.—The latest information (if any)  
25 maintained by the plan, or by any health

1 insurance issuer offering health insurance  
2 coverage in connection with the plan, relat-  
3 ing to quality of performance of the deliv-  
4 ery of medical care with respect to cov-  
5 erage options offered under the plan and  
6 of health care professionals and facilities  
7 providing medical care under the plan.

8 “(ix) INFORMATION RELATING TO EX-  
9 TERNAL REVIEWS.—The number of exter-  
10 nal reviews under section 503(b)(4) of the  
11 Employee Retirement Income Security Act  
12 of 1974 that have been completed during  
13 the prior plan year and the number of such  
14 reviews in which the recommendation re-  
15 ported under section 503(b)(4)(C)(iii) of  
16 such Act includes a recommendation for  
17 modification or reversal of an internal re-  
18 view decision under the plan.

19 “(C) INFORMATION REQUIRED FROM  
20 HEALTH CARE PROFESSIONALS ON REQUEST.—  
21 Any health care professional treating a partici-  
22 pant or beneficiary under a group health plan  
23 shall provide to the participant or beneficiary,  
24 on request, a description of his or her profes-  
25 sional qualifications (including board certifi-

1 cation status, licensing status, and accreditation  
2 status, if any), privileges, and experience and a  
3 general description by category (including sal-  
4 ary, fee-for-service, capitation, and such other  
5 categories as may be specified in regulations of  
6 the Secretary) of the applicable method by  
7 which such professional is compensated in con-  
8 nection with the provision of such medical care.

9 “(D) INFORMATION REQUIRED FROM  
10 HEALTH CARE FACILITIES ON REQUEST.—Any  
11 health care facility from which a participant or  
12 beneficiary has sought treatment under a group  
13 health plan shall provide to the participant or  
14 beneficiary, on request, a description of the fa-  
15 cility’s corporate form or other organizational  
16 form and all forms of licensing and accredita-  
17 tion status (if any) assigned to the facility by  
18 standard-setting organizations.

19 “(f) ACCESS TO INFORMATION RELEVANT TO THE  
20 COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR  
21 BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to  
22 information otherwise required to be made available under  
23 this section, a group health plan shall, upon written re-  
24 quest (made not more frequently than annually), make  
25 available to a participant (and an employee who, under



1 the terms of the plan, is eligible for coverage but not en-  
2 rolled) in connection with a period of enrollment the sum-  
3 mary plan description for any coverage option under the  
4 plan under which the participant is eligible to enroll and  
5 any information described in clauses (i), (ii), (iii), (vi),  
6 (vii), and (viii) of subsection (e)(2)(B).

7 “(g) ADVANCE NOTICE OF CHANGES IN DRUG  
8 FORMULARIES.—Not later than 30 days before the effec-  
9 tive of date of any exclusion of a specific drug or biological  
10 from any drug formulary under the plan that is used in  
11 the treatment of a chronic illness or disease, the plan shall  
12 take such actions as are necessary to reasonably ensure  
13 that plan participants are informed of such exclusion. The  
14 requirements of this subsection may be satisfied—

15 “(1) by inclusion of information in publications  
16 broadly distributed by plan sponsors, employers, or  
17 employee organizations;

18 “(2) by electronic means of communication (in-  
19 cluding the Internet or proprietary computer net-  
20 works in a format which is readily accessible to par-  
21 ticipants);

22 “(3) by timely informing participants who,  
23 under an ongoing program maintained under the  
24 plan, have submitted their names for such notifica-  
25 tion; or

1           “(4) by any other reasonable means of timely  
2           informing plan participants.”.

3           (b) CLERICAL AMENDMENT.—The table of sections  
4           of such subchapter of such chapter is amended by adding  
5           at the end the following new item:

                  “Sec. 9814. Disclosure by group health plans.”.

6   **SEC. 3102. EFFECTIVE DATE.**

7           (a) IN GENERAL.—The amendments made by this  
8           subtitle shall apply with respect to plan years beginning  
9           on or after January 1 of the second calendar year follow-  
10          ing the date of the enactment of this Act. The Secretary  
11          of the Treasury or the Secretary’s delegate shall first issue  
12          all regulations necessary to carry out the amendments  
13          made by this subtitle before such date.

14          (b) LIMITATION ON ENFORCEMENT ACTIONS.—No  
15          enforcement action shall be taken, pursuant to the amend-  
16          ments made by this subtitle, against a group health plan  
17          with respect to a violation of a requirement imposed by  
18          such amendments before the date of issuance of final regu-  
19          lations issued in connection with such requirement, if the  
20          plan has sought to comply in good faith with such require-  
21          ment.

## **Subtitle C—Medical Savings Accounts**

### **SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAV- INGS ACCOUNTS.**

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking “and such employer is a small employer”.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and

1           by redesignating paragraph (5) as paragraph  
2           (4).

3           (c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED  
4   FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

5           (1) IN GENERAL.—Paragraph (2) of section  
6   220(b) of such Code is amended to read as follows:

7           “(2) MONTHLY LIMITATION.—The monthly lim-  
8   itation for any month is the amount equal to  $\frac{1}{12}$  of  
9   the annual deductible (as of the first day of such  
10   month) of the taxpayer’s coverage under the high  
11   deductible health plan.”.

12          (2) CONFORMING AMENDMENT.—Clause (ii) of  
13   section 220(d)(1)(A) of such Code is amended by  
14   striking “75 percent of”.

15          (d) BOTH EMPLOYERS AND EMPLOYEES MAY CON-  
16   TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph  
17   (5) of section 220(b) of such Code is amended to read  
18   as follows:

19          “(5) COORDINATION WITH EXCLUSION FOR EM-  
20   PLOYER CONTRIBUTIONS.—The limitation which  
21   would (but for this paragraph) apply under this sub-  
22   section to the taxpayer for any taxable year shall be  
23   reduced (but not below zero) by the amount which  
24   would (but for section 106(b)) be includible in the  
25   taxpayer’s gross income for such taxable year.”.

1       (e) REDUCTION OF PERMITTED DEDUCTIBLES  
2 UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

3           (1) IN GENERAL.—Subparagraph (A) of section  
4       220(c)(2) of such Code (defining high deductible  
5       health plan) is amended—

6           (A) by striking “\$1,500” and inserting  
7       “\$1,000”; and

8           (B) by striking “\$3,000” and inserting  
9       “\$2,000”.

10          (2) CONFORMING AMENDMENT.—Subsection (g)  
11       of section 220 of such Code is amended—

12          (A) by striking “1998” and inserting  
13       “1999”; and

14          (B) by striking “1997” and inserting  
15       “1998”.

16       (f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED  
17 UNDER CAFETERIA PLANS.—Subsection (f) of section  
18 125 of such Code is amended by striking “106(b),”.

19       (g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL  
20 ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS AC-  
21 COUNTS.—Paragraph (1) of section 220(c) of such Code  
22 (defining eligible individual), as amended by subsections  
23 (a) and (b), is amended by adding at the end the following  
24 new subparagraph:

1                   “(C) SPECIAL RULES FOR INDIVIDUALS  
2 RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

3                   “(i) IN GENERAL.—Subparagraph  
4 (A)(iii) and subsection (b)(4) shall not  
5 apply for any month to an individual—

6                   “(I) who, as of the first day of  
7 such month, is enrolled in a high de-  
8 ductible health plan under chapter 89  
9 of title 5, United States Code; and

10                  “(II) who is entitled to receive  
11 for such month any amount by reason  
12 of being an annuitant (as defined in  
13 section 8901(3) of such title 5).

14                  “(ii) SPECIAL RULE FOR SPOUSE OF  
15 ANNUITANT.—In the case of the spouse of  
16 an individual described in clause (i) who is  
17 not also described in clause (i), subsection  
18 (b)(4) shall not apply to such spouse if  
19 such individual and spouse have family  
20 coverage under the same plan described in  
21 clause (i)(I).”.

22                  (h) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to taxable years ending after the  
24 date of the enactment of this Act.

1 **SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN**  
2 **CASE OF MEDICAL SAVINGS ACCOUNTS.**

3 (a) IN GENERAL.—Section 220(d)(2)(B) of the Inter-  
4 nal Revenue Code of 1986 is amended by adding at the  
5 end the following new clause:

6 “(iii) INSURANCE OFFERED BY COM-  
7 MUNITY HEALTH CENTERS.—

8 “(I) IN GENERAL.—Subject to  
9 clauses (II) and (III), clause (i) shall  
10 not apply to any expense for coverage  
11 under insurance offered by a health  
12 center (as defined in section 330(a)(1)  
13 of the Public Health Service Act) if  
14 the coverage consists solely of cov-  
15 erage for required primary health ben-  
16 efits (as defined in section  
17 330(b)(1)(A) of such Act) provided on  
18 a capitated basis.

19 “(II) INCOME LIMITATION.—Sub-  
20 clause (I) shall only apply to expenses  
21 for coverage of an individual who, in  
22 the taxable year involved, has income  
23 that is less than 200 percent of the  
24 income official poverty line (as defined  
25 by the Office of Management and  
26 Budget, and revised annually in ac-

1 cordance with section 673(2) of the  
2 Omnibus Budget Reconciliation Act of  
3 1981) applicable to a family of the  
4 size involved.

5 “(III) LIMITATION ON NUMBER  
6 OF CONTRACTS.—For a taxable year  
7 ending in a calendar year, subclause  
8 (I) shall apply only to expenses for  
9 coverage for the first 15,000 individ-  
10 uals enrolled in insurance described in  
11 such subclause in the year.”.

12 (b) REPORTS ON ENROLLMENT.—Section 330(j)(3)  
13 of the Public Health Service Act (42 U.S.C. 254c(j)(3))  
14 is amended—

15 (1) by striking “and” at the end of subpara-  
16 graph (K);

17 (2) by striking the period at the end of sub-  
18 paragraph (L) and inserting “; and”; and

19 (3) by inserting after subparagraph (L) the fol-  
20 lowing new subparagraph:

21 “(M) if the center offers insurance cov-  
22 erage to an individual with a medical savings  
23 account under subclause (I) of section  
24 220(d)(2)(B)(iii), the center shall provide such  
25 reports in such time and manner as may be re-



1           quired by the Secretary and the Secretary of  
 2           the Treasury in order to carry out subclause  
 3           (III) of such section.”.

4   **SEC. 3203. SENSE OF THE HOUSE OF REPRESENTATIVES.**

5           It is the sense of the House of Representatives that  
 6   patients are best served when they are empowered to make  
 7   informed choices about their own health care. The same  
 8   is true regarding an individual’s choice of health insur-  
 9   ance. A system that gives people the power to choose the  
 10  coverage that best meets their needs, combined with insur-  
 11  ance market reforms, offers great promise of increased  
 12  choices and greater access to health insurance for Ameri-  
 13  cans.

14           **Subtitle D—Revenue Offsets**

15   **SEC. 3301. CLARIFICATION OF DEFINITION OF SPECIFIED**  
 16           **LIABILITY LOSS.**

17           (a) IN GENERAL.—Subparagraph (B) of section  
 18  172(f)(1) of the Internal Revenue Code of 1986 (defining  
 19  specified liability loss) is amended to read as follows:

20                   “(B)(i) Any amount allowable as a deduc-  
 21           tion under this chapter (other than section  
 22           468(a)(1) or 468A(a)) which is in satisfaction  
 23           of a liability under a Federal or State law re-  
 24           quiring—

25                   “(I) the reclamation of land;

1 “(II) the decommissioning of a nu-  
2 clear power plant (or any unit thereof);

3 “(III) the dismantlement of a drilling  
4 platform;

5 “(IV) the remediation of environ-  
6 mental contamination; or

7 “(V) a payment under any workers  
8 compensation act (within the meaning of  
9 section 461(h)(2)(C)(i)).

10 “(ii) A liability shall be taken into account  
11 under this subparagraph only if—

12 “(I) the act (or failure to act) giving  
13 rise to such liability occurs at least 3 years  
14 before the beginning of the taxable year;  
15 and

16 “(II) the taxpayer used an accrual  
17 method of accounting throughout the pe-  
18 riod or periods during which such act (or  
19 failure to act) occurred.”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 this section shall apply to net operating losses arising in  
22 taxable years ending after the date of the enactment of  
23 this Act.

1 **SEC. 3302. PROPERTY SUBJECT TO A LIABILITY TREATED**  
2 **IN SAME MANNER AS ASSUMPTION OF LI-**  
3 **ABILITY.**

4 (a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY  
5 TEST.—

6 (1) SECTION 357.—Section 357(a) of the Inter-  
7 nal Revenue Code of 1986 (relating to assumption  
8 of liability) is amended by striking “, or acquires  
9 from the taxpayer property subject to a liability” in  
10 paragraph (2).

11 (2) SECTION 358.—Section 358(d)(1) of such  
12 Code (relating to assumption of liability) is amended  
13 by striking “or acquired from the taxpayer property  
14 subject to a liability”.

15 (3) SECTION 368.—

16 (A) Section 368(a)(1)(C) of such Code is  
17 amended by striking “, or the fact that prop-  
18 erty acquired is subject to a liability,”.

19 (B) The last sentence of section  
20 368(a)(2)(B) of such Code is amended by strik-  
21 ing “, and the amount of any liability to which  
22 any property acquired from the acquiring cor-  
23 poration is subject,”.

24 (b) CLARIFICATION OF ASSUMPTION OF LIABIL-  
25 ITY.—

1           (1) IN GENERAL.—Section 357 of such Code is  
2       amended by adding at the end the following new  
3       subsections:

4       “(d) DETERMINATION OF AMOUNT OF LIABILITY AS-  
5       SUMED.—

6           “(1) IN GENERAL.—For purposes of this sec-  
7       tion, section 358(d), section 362(d), section  
8       368(a)(1)(C), and section 368(a)(2)(B), except as  
9       provided in regulations—

10           “(A) a recourse liability (or portion there-  
11       of) shall be treated as having been assumed if,  
12       as determined on the basis of all facts and cir-  
13       cumstances, the transferee has agreed to, and is  
14       expected to, satisfy such liability (or portion),  
15       whether or not the transferor has been relieved  
16       of such liability; and

17           “(B) a nonrecourse liability shall be treat-  
18       ed as having been assumed by the transferee of  
19       any asset subject to such liability.

20           “(2) REGULATIONS.—The Secretary shall pre-  
21       scribe such regulations as may be necessary to carry  
22       out the purposes of this subsection and section  
23       362(d). The Secretary may also prescribe regula-  
24       tions which provide that the manner in which a li-  
25       ability is treated as assumed under this subsection

1 is applied, where appropriate, elsewhere in this  
 2 title.”.

3 (2) LIMITATION ON BASIS INCREASE ATTRIB-  
 4 UTABLE TO ASSUMPTION OF LIABILITY.—Section  
 5 362 of such Code is amended by adding at the end  
 6 the following new subsection:

7 “(d) LIMITATION ON BASIS INCREASE ATTRIB-  
 8 UTABLE TO ASSUMPTION OF LIABILITY.—

9 “(1) IN GENERAL.—In no event shall the basis  
 10 of any property be increased under subsection (a) or  
 11 (b) above fair market value (determined without re-  
 12 gard to section 7701(g)) by reason of any gain rec-  
 13 ognized to the transferor as a result of the assump-  
 14 tion of a liability.

15 “(2) TREATMENT OF GAIN NOT SUBJECT TO  
 16 TAX.—Except as provided in regulations, if—

17 “(A) gain is recognized to the transferor as  
 18 a result of an assumption of a nonrecourse li-  
 19 ability by a transferee which is also secured by  
 20 assets not transferred to such transferee; and

21 “(B) no person is subject to tax under this  
 22 title on such gain,  
 23 then, for purposes of determining basis under sub-  
 24 sections (a) and (b), the amount of gain recognized  
 25 by the transferor as a result of the assumption of

1 the liability shall be determined as if the liability as-  
 2 sumed by the transferee equaled such transferee's  
 3 ratable portion of such liability determined on the  
 4 basis of the relative fair market values (determined  
 5 without regard to section 7701(g)) of all of the as-  
 6 sets subject to such liability.”.

7 (c) APPLICATION TO PROVISIONS OTHER THAN SUB-  
 8 CHAPTER C.—

9 (1) SECTION 584.—Section 584(h)(3) of such  
 10 Code is amended—

11 (A) by striking “, and the fact that any  
 12 property transferred by the common trust fund  
 13 is subject to a liability,” in subparagraph (A);  
 14 and

15 (B) by striking clause (ii) of subparagraph  
 16 (B) and inserting:

17 “(ii) ASSUMED LIABILITIES.—For  
 18 purposes of clause (i), the term ‘assumed  
 19 liabilities’ means any liability of the com-  
 20 mon trust fund assumed by any regulated  
 21 investment company in connection with the  
 22 transfer referred to in paragraph (1)(A).

23 “(C) ASSUMPTION.—For purposes of this  
 24 paragraph, in determining the amount of any li-

1           ability assumed, the rules of section 357(d)  
2           shall apply.”.

3           (2) SECTION 1031.—The last sentence of section  
4           1031(d) of such Code is amended—

5                   (A) by striking “assumed a liability of the  
6                   taxpayer or acquired from the taxpayer prop-  
7                   erty subject to a liability” and inserting “as-  
8                   sumed (as determined under section 357(d)) a  
9                   liability of the taxpayer”; and

10                   (B) by striking “or acquisition (in the  
11                   amount of the liability)”.

12           (d) CONFORMING AMENDMENTS.—

13                   (1) Section 351(h)(1) of such Code is amended  
14                   by striking “, or acquires property subject to a li-  
15                   ability,”.

16                   (2) Section 357 of such Code is amended by  
17                   striking “or acquisition” each place it appears in  
18                   subsection (a) or (b).

19                   (3) Section 357(b)(1) of such Code is amended  
20                   by striking “or acquired”.

21                   (4) Section 357(c)(1) of such Code is amended  
22                   by striking “, plus the amount of the liabilities to  
23                   which the property is subject,”.

1           (5) Section 357(c)(3) of such Code is amended  
2       by striking “or to which the property transferred is  
3       subject”.

4           (6) Section 358(d)(1) of such Code is amended  
5       by striking “or acquisition (in the amount of the li-  
6       ability)”.

7       (e) EFFECTIVE DATE.—The amendments made by  
8       this section shall apply to transfers after the date of the  
9       enactment of this Act.

10   **SEC. 3303. LIMITATION ON REQUIRED ACCRUAL OF**  
11                   **AMOUNTS RECEIVED FOR PERFORMANCE OF**  
12                   **CERTAIN PERSONAL SERVICES.**

13       (a) IN GENERAL.—Paragraph (5) of section 448(d)  
14       of the Internal Revenue Code of 1986 (relating to special  
15       rule for services) is amended by inserting “in fields re-  
16       ferred to in paragraph (2)(A)” after “services by such per-  
17       son”.

18       (b) EFFECTIVE DATE.—The amendment made by  
19       subsection (a) shall apply to taxable years beginning after  
20       December 31, 1998.

21       (c) COORDINATION WITH SECTION 481.—In the case  
22       of any taxpayer required by this section to change its  
23       method of accounting for any taxable year—

24           (1) such change shall be treated as initiated by  
25       the taxpayer;



1           (2) such change shall be treated as made with  
2           the consent of the Secretary of the Treasury; and

3           (3) the period for taking into account the ad-  
4           justments under section 481 by reason of such  
5           change shall be 3 years.

6 **SEC. 3304. RETURNS RELATING TO CANCELLATIONS OF IN-**  
7 **DEBTEDNESS BY ORGANIZATIONS LENDING**  
8 **MONEY.**

9           (a) IN GENERAL.—Paragraph (2) of section  
10 6050P(c) of the Internal Revenue Code of 1986 (relating  
11 to definitions and special rules) is amended by striking  
12 “and” at the end of subparagraph (B), by striking the  
13 period at the end of subparagraph (C) and inserting “;  
14 and”, and by inserting after subparagraph (C) the follow-  
15 ing new subparagraph:

16                     “(D) any organization a significant trade  
17                     or business of which is the lending of money.”.

18           (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply to discharges of indebtedness  
20 after December 31, 1998.

21 **SEC. 3305. CLARIFICATION AND EXPANSION OF MATHE-**  
22 **MATICAL ERROR ASSESSMENT PROCEDURES.**

23           (a) TIN DEEMED INCORRECT IF INFORMATION ON  
24 RETURN DIFFERS WITH AGENCY RECORDS.—Section  
25 6213(g)(2) of the Internal Revenue Code of 1986 (defin-

1 ing mathematical or clerical error) is amended by adding  
2 at the end the following flush sentence:

3 “A taxpayer shall be treated as having omitted a  
4 correct TIN for purposes of the preceding sentence  
5 if information provided by the taxpayer on the re-  
6 turn with respect to the individual whose TIN was  
7 provided differs from the information the Secretary  
8 obtains from the person issuing the TIN.”.

9 (b) EXPANSION OF MATHEMATICAL ERROR PROCE-  
10 DURES TO CASES WHERE TIN ESTABLISHES INDIVIDUAL  
11 NOT ELIGIBLE FOR TAX CREDIT.—Section 6213(g)(2) of  
12 such Code is amended by striking “and” at the end of  
13 subparagraph (J), by striking the period at the end of the  
14 subparagraph (K) and inserting “; and”, and by adding  
15 at the end the following new subparagraph:

16 “(L) the inclusion on a return of a TIN re-  
17 quired to be included on the return under sec-  
18 tion 21, 24, or 32 if—

19 “(i) such TIN is of an individual  
20 whose age affects the amount of the credit  
21 under such section; and

22 “(ii) the computation of the credit on  
23 the return reflects the treatment of such  
24 individual as being of an age different

1 from the individual's age based on such  
2 TIN.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to taxable years ending after the  
5 date of the enactment of this Act.

6 **SEC. 3306. INCLUSION OF ROTAVIRUS GASTROENTERITIS**  
7 **AS A TAXABLE VACCINE.**

8 (a) IN GENERAL.—Section 4132(1) of the Internal  
9 Revenue Code of 1986 (defining taxable vaccine) is  
10 amended by adding at the end the following new subpara-  
11 graph:

12 “(K) Any vaccine against rotavirus  
13 gastroenteritis.”.

14 (b) EFFECTIVE DATE.—

15 (1) SALES.—The amendment made by this sec-  
16 tion shall apply to sales after the date of the enact-  
17 ment of this Act.

18 (2) DELIVERIES.—For purposes of paragraph  
19 (1), in the case of sales on or before the date of the  
20 enactment of this Act for which delivery is made  
21 after such date, the delivery date shall be considered  
22 the sale date.

1           **TITLE IV—HEALTH CARE**  
2           **LAWSUIT REFORM**  
3           **Subtitle A—General Provisions**

4   **SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY**  
5           **ACTIONS.**

6           (a) **APPLICABILITY.**—This title shall apply with re-  
7 spect to any health care liability action brought in any  
8 State or Federal court, except that this title shall not  
9 apply to—

10           (1) an action for damages arising from a vac-  
11 cine-related injury or death to the extent that title  
12 XXI of the Public Health Service Act applies to the  
13 action; or

14           (2) an action under the Employee Retirement  
15 Income Security Act of 1974 (29 U.S.C. 1001 et  
16 seq.).

17           (b) **PREEMPTION.**—This title shall preempt any State  
18 law to the extent such law is inconsistent with the limita-  
19 tions contained in this title. This title shall not preempt  
20 any State law that provides for defenses or places limita-  
21 tions on a person’s liability in addition to those contained  
22 in this title or otherwise imposes greater restrictions than  
23 those provided in this title.

1       (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
3 construed to—

4           (1) waive or affect any defense of sovereign im-  
5 munity asserted by any State under any provision of  
6 law;

7           (2) waive or affect any defense of sovereign im-  
8 munity asserted by the United States;

9           (3) affect the applicability of any provision of  
10 the Foreign Sovereign Immunities Act of 1976;

11          (4) preempt State choice-of-law rules with re-  
12 spect to claims brought by a foreign nation or a citi-  
13 zen of a foreign nation; or

14          (5) affect the right of any court to transfer  
15 venue or to apply the law of a foreign nation or to  
16 dismiss a claim of a foreign nation or of a citizen  
17 of a foreign nation on the ground of inconvenient  
18 forum.

19       (d) AMOUNT IN CONTROVERSY.—In an action to  
20 which this title applies and which is brought under section  
21 1332 of title 28, United States Code, the amount of non-  
22 economic damages or punitive damages, and attorneys'  
23 fees or costs, shall not be included in determining whether  
24 the matter in controversy exceeds the sum or value of  
25 \$50,000.

1       (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
2 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
3 this title shall be construed to establish any jurisdiction  
4 in the district courts of the United States over health care  
5 liability actions on the basis of section 1331 or 1337 of  
6 title 28, United States Code.

7 **SEC. 4002. DEFINITIONS.**

8       As used in this title:

9           (1) ACTUAL DAMAGES.—The term “actual dam-  
10 ages” means damages awarded to pay for economic  
11 loss.

12          (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
13 TEM; ADR.—The term “alternative dispute resolution  
14 system” or “ADR” means a system established  
15 under Federal or State law that provides for the res-  
16 olution of health care liability claims in a manner  
17 other than through health care liability actions.

18          (3) CLAIMANT.—The term “claimant” means  
19 any person who brings a health care liability action  
20 and any person on whose behalf such an action is  
21 brought. If such action is brought through or on be-  
22 half of an estate, the term includes the claimant’s  
23 decedent. If such action is brought through or on be-  
24 half of a minor or incompetent, the term includes  
25 the claimant’s legal guardian.

1           (4) CLEAR AND CONVINCING EVIDENCE.—The  
2       term “clear and convincing evidence” is that meas-  
3       ure or degree of proof that will produce in the mind  
4       of the trier of fact a firm belief or conviction as to  
5       the truth of the allegations sought to be established.  
6       Such measure or degree of proof is more than that  
7       required under preponderance of the evidence but  
8       less than that required for proof beyond a reason-  
9       able doubt.

10          (5) COLLATERAL SOURCE PAYMENTS.—The  
11       term “collateral source payments” means any  
12       amount paid or reasonably likely to be paid in the  
13       future to or on behalf of a claimant, or any service,  
14       product, or other benefit provided or reasonably like-  
15       ly to be provided in the future to or on behalf of a  
16       claimant, as a result of an injury or wrongful death,  
17       pursuant to—

18                (A) any State or Federal health, sickness,  
19       income-disability, accident or workers’ com-  
20       pensation Act;

21                (B) any health, sickness, income-disability,  
22       or accident insurance that provides health bene-  
23       fits or income-disability coverage;

24                (C) any contract or agreement of any  
25       group, organization, partnership, or corporation

1 to provide, pay for, or reimburse the cost of  
2 medical, hospital, dental, or income disability  
3 benefits; and

4 (D) any other publicly or privately funded  
5 program.

6 (6) DRUG.—The term “drug” has the meaning  
7 given such term in section 201(g)(1) of the Federal  
8 Food, Drug, and Cosmetic Act (21 U.S.C.  
9 321(g)(1)).

10 (7) ECONOMIC LOSS.—The term “economic  
11 loss” means any pecuniary loss resulting from injury  
12 (including the loss of earnings or other benefits re-  
13 lated to employment, medical expense loss, replace-  
14 ment services loss, loss due to death, burial costs,  
15 and loss of business or employment opportunities),  
16 to the extent recovery for such loss is allowed under  
17 applicable State law.

18 (8) HARM.—The term “harm” means any le-  
19 gally cognizable wrong or injury for which punitive  
20 damages may be imposed.

21 (9) HEALTH BENEFIT PLAN.—The term  
22 “health benefit plan” means—

23 (A) a hospital or medical expense incurred  
24 policy or certificate;



1 (B) a hospital or medical service plan con-  
2 tract;

3 (C) a health maintenance subscriber con-  
4 tract; or

5 (D) a Medicare+Choice plan (offered  
6 under part C of title XVIII of the Social Secu-  
7 rity Act),

8 that provides benefits with respect to health care  
9 services.

10 (10) HEALTH CARE LIABILITY ACTION.—The  
11 term “health care liability action” means a civil ac-  
12 tion brought in a State or Federal court against—

13 (A) a health care provider;

14 (B) an entity which is obligated to provide  
15 or pay for health benefits under any health ben-  
16 efit plan (including any person or entity acting  
17 under a contract or arrangement to provide or  
18 administer any health benefit); or

19 (C) the manufacturer, distributor, supplier,  
20 marketer, promoter, or seller of a medical prod-  
21 uct,

22 in which the claimant alleges a claim (including third  
23 party claims, cross claims, counter claims, or contribution  
24 claims) based upon the provision of (or the failure to pro-  
25 vide or pay for) health care services or the use of a medical

1 product, regardless of the theory of liability on which the  
2 claim is based or the number of plaintiffs, defendants, or  
3 causes of action.

4 (11) HEALTH CARE LIABILITY CLAIM.—The  
5 term “health care liability claim” means a claim in  
6 which the claimant alleges that injury was caused by  
7 the provision of (or the failure to provide) health  
8 care services.

9 (12) HEALTH CARE PROVIDER.—The term  
10 “health care provider” means any person that is en-  
11 gaged in the delivery of health care services in a  
12 State and that is required by the laws or regulations  
13 of the State to be licensed or certified by the State  
14 to engage in the delivery of such services in the  
15 State.

16 (13) HEALTH CARE SERVICE.—The term  
17 “health care service” means any service eligible for  
18 payment under a health benefit plan, including serv-  
19 ices related to the delivery or administration of such  
20 service.

21 (14) MEDICAL DEVICE.—The term “medical de-  
22 vice” has the meaning given such term in section  
23 201(h) of the Federal Food, Drug, and Cosmetic  
24 Act (21 U.S.C. 321(h)).

1           (15) NON-ECONOMIC DAMAGES.—The term  
2           “non-economic damages” means damages paid to an  
3           individual for pain and suffering, inconvenience,  
4           emotional distress, mental anguish, loss of consor-  
5           tium, injury to reputation, humiliation, and other  
6           nonpecuniary losses.

7           (16) PERSON.—The term “person” means any  
8           individual, corporation, company, association, firm,  
9           partnership, society, joint stock company, or any  
10          other entity, including any governmental entity.

11          (17) PRODUCT SELLER.—

12                (A) IN GENERAL.—Subject to subpara-  
13               graph (B), the term “product seller” means a  
14               person who, in the course of a business con-  
15               ducted for that purpose—

16                   (i) sells, distributes, rents, leases, pre-  
17                   pares, blends, packages, labels, or is other-  
18                   wise involved in placing, a product in the  
19                   stream of commerce; or

20                   (ii) installs, repairs, or maintains the  
21                   harm-causing aspect of a product.

22                (B) EXCLUSION.—Such term does not in-  
23               clude—

24                   (i) a seller or lessor of real property;

1 (ii) a provider of professional services  
2 in any case in which the sale or use of a  
3 product is incidental to the transaction and  
4 the essence of the transaction is the fur-  
5 nishing of judgment, skill, or services; or

6 (iii) any person who—

7 (I) acts in only a financial capac-  
8 ity with respect to the sale of a prod-  
9 uct; or

10 (II) leases a product under a  
11 lease arrangement in which the selec-  
12 tion, possession, maintenance, and op-  
13 eration of the product are controlled  
14 by a person other than the lessor.

15 (18) PUNITIVE DAMAGES.—The term “punitive  
16 damages” means damages awarded against any per-  
17 son not to compensate for actual injury suffered, but  
18 to punish or deter such person or others from en-  
19 gaging in similar behavior in the future.

20 (19) STATE.—The term “State” means each of  
21 the several States, the District of Columbia, Puerto  
22 Rico, the Virgin Islands, Guam, American Samoa,  
23 the Northern Mariana Islands, and any other terri-  
24 tory or possession of the United States.

1 **SEC. 4003. EFFECTIVE DATE.**

2 This title will apply to—

3 (1) any health care liability action brought in a  
4 Federal or State court; and

5 (2) any health care liability claim subject to an  
6 alternative dispute resolution system,

7 that is initiated on or after the date of enactment of this  
8 title, except that any health care liability claim or action  
9 arising from an injury occurring before the date of enact-  
10 ment of this title shall be governed by the applicable stat-  
11 ute of limitations provisions in effect at the time the injury  
12 occurred.

13 **Subtitle B—Uniform Standards for**  
14 **Health Care Liability Actions**

15 **SEC. 4011. STATUTE OF LIMITATIONS.**

16 A health care liability action may not be brought  
17 after the expiration of the 2-year period that begins on  
18 the date on which the alleged injury that is the subject  
19 of the action was discovered or should reasonably have  
20 been discovered, but in no case after the expiration of the  
21 5-year period that begins on the date the alleged injury  
22 occurred.

23 **SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.**

24 (a) TREATMENT OF NON-ECONOMIC DAMAGES.—

25 (1) LIMITATION ON NON-ECONOMIC DAM-  
26 AGES.—The total amount of non-economic damages

1       that may be awarded to a claimant for losses result-  
2       ing from the injury which is the subject of a health  
3       care liability action may not exceed \$250,000, re-  
4       gardless of the number of parties against whom the  
5       action is brought or the number of actions brought  
6       with respect to the injury. The limitation under this  
7       paragraph shall not apply to an action for damages  
8       based solely on intentional denial of medical treat-  
9       ment necessary to preserve a patient's life that the  
10      patient is otherwise qualified to receive, against the  
11      wishes of a patient, or if the patient is incompetent,  
12      against the wishes of the patient's guardian, on the  
13      basis of the patient's present or predicated age, dis-  
14      ability, degree of medical dependency, or quality of  
15      life.

16           (2) LIMIT.—If, after the date of the enactment  
17      of this Act, a State enacts a law which prescribes  
18      the amount of non-economic damages which may be  
19      awarded in a health care liability action which is dif-  
20      ferent from the amount prescribed by section  
21      4012(a)(1), the State amount shall apply in lieu of  
22      the amount prescribed by such section. If, after the  
23      date of the enactment of this Act, a State enacts a  
24      law which limits the amount of recovery in a health  
25      care liability action without delineating between eco-

1        nomic and non-economic damages, the State amount  
2        shall apply in lieu of the amount prescribed by such  
3        section.

4            (3) JOINT AND SEVERAL LIABILITY.—In any  
5        health care liability action brought in State or Fed-  
6        eral court, a defendant shall be liable only for the  
7        amount of non-economic damages attributable to  
8        such defendant in direct proportion to such defend-  
9        ant's share of fault or responsibility for the claim-  
10      ant's actual damages, as determined by the trier of  
11      fact. In all such cases, the liability of a defendant  
12      for non-economic damages shall be several and not  
13      joint and a separate judgment shall be rendered  
14      against each defendant for the amount allocated to  
15      such defendant.

16      (b) TREATMENT OF PUNITIVE DAMAGES.—

17            (1) GENERAL RULE.—Punitive damages may,  
18      to the extent permitted by applicable State law, be  
19      awarded in any health care liability action for harm  
20      in any Federal or State court against a defendant if  
21      the claimant establishes by clear and convincing evi-  
22      dence that the harm suffered was the result of con-  
23      duct—

24            (A) specifically intended to cause harm; or

1 (B) conduct manifesting a conscious, fla-  
2 grant indifference to the rights or safety of oth-  
3 ers.

4 (2) APPLICABILITY.—This subsection shall  
5 apply to any health care liability action brought in  
6 any Federal or State court on any theory where pu-  
7 nitive damages are sought. This subsection does not  
8 create a cause of action for punitive damages. This  
9 subsection does not preempt or supersede any State  
10 or Federal law to the extent that such law would  
11 further limit the award of punitive damages.

12 (3) BIFURCATION.—At the request of any  
13 party, the trier of fact shall consider in a separate  
14 proceeding whether punitive damages are to be  
15 awarded and the amount of such award. If a sepa-  
16 rate proceeding is requested, evidence relevant only  
17 to the claim of punitive damages, as determined by  
18 applicable State law, shall be inadmissible in any  
19 proceeding to determine whether actual damages are  
20 to be awarded.

21 (4) DRUGS AND DEVICES.—

22 (A) IN GENERAL.—

23 (i) PUNITIVE DAMAGES.—Punitive  
24 damages shall not be awarded against a  
25 manufacturer or product seller of a drug



1 or medical device which caused the claim-  
2 ant's harm where—

3 (I) such drug or device was sub-  
4 ject to premarket approval by the  
5 Food and Drug Administration with  
6 respect to the safety of the formula-  
7 tion or performance of the aspect of  
8 such drug or device which caused the  
9 claimant's harm, or the adequacy of  
10 the packaging or labeling of such drug  
11 or device which caused the harm, and  
12 such drug, device, packaging, or label-  
13 ing was approved by the Food and  
14 Drug Administration; or

15 (II) the drug is generally recog-  
16 nized as safe and effective pursuant to  
17 conditions established by the Food  
18 and Drug Administration and applica-  
19 ble regulations, including packaging  
20 and labeling regulations.

21 (ii) APPLICATION.—Clause (i) shall  
22 not apply in any case in which the defend-  
23 ant, before or after premarket approval of  
24 a drug or device—

1 (I) intentionally and wrongfully  
2 withheld from or misrepresented to  
3 the Food and Drug Administration in-  
4 formation concerning such drug or de-  
5 vice required to be submitted under  
6 the Federal Food, Drug, and Cos-  
7 metic Act (21 U.S.C. 301 et seq.) or  
8 section 351 of the Public Health Serv-  
9 ice Act (42 U.S.C. 262) that is mate-  
10 rial and relevant to the harm suffered  
11 by the claimant; or

12 (II) made an illegal payment to  
13 an official or employee of the Food  
14 and Drug Administration for the pur-  
15 pose of securing or maintaining ap-  
16 proval of such drug or device.

17 (B) PACKAGING.—In a health care liability  
18 action for harm which is alleged to relate to the  
19 adequacy of the packaging or labeling of a drug  
20 which is required to have tamper-resistant  
21 packaging under regulations of the Secretary of  
22 Health and Human Services (including labeling  
23 regulations related to such packaging), the  
24 manufacturer or product seller of the drug shall  
25 not be held liable for punitive damages unless

1           such packaging or labeling is found by the court  
2           by clear and convincing evidence to be substan-  
3           tially out of compliance with such regulations.

4       (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

5           (1) GENERAL RULE.—In any health care liabil-  
6           ity action in which the damages awarded for future  
7           economic and non-economic loss exceeds \$50,000, a  
8           person shall not be required to pay such damages in  
9           a single, lump-sum payment, but shall be permitted  
10          to make such payments periodically based on when  
11          the damages are likely to occur, as such payments  
12          are determined by the court.

13          (2) FINALITY OF JUDGMENT.—The judgment  
14          of the court awarding periodic payments under this  
15          subsection may not, in the absence of fraud, be re-  
16          opened at any time to contest, amend, or modify the  
17          schedule or amount of the payments.

18          (3) LUMP-SUM SETTLEMENTS.—This sub-  
19          section shall not be construed to preclude a settle-  
20          ment providing for a single, lump-sum payment.

21       (d) TREATMENT OF COLLATERAL SOURCE PAY-  
22       MENTS.—

23           (1) INTRODUCTION INTO EVIDENCE.—In any  
24           health care liability action, any defendant may intro-  
25           duce evidence of collateral source payments. If any

1 defendant elects to introduce such evidence, the  
2 claimant may introduce evidence of any amount paid  
3 or contributed or reasonably likely to be paid or con-  
4 tributed in the future by or on behalf of the claim-  
5 ant to secure the right to such collateral source pay-  
6 ments.

7 (2) NO SUBROGATION.—No provider of collat-  
8 eral source payments shall recover any amount  
9 against the claimant or receive any lien or credit  
10 against the claimant's recovery or be equitably or le-  
11 gally subrogated to the right of the claimant in a  
12 health care liability action.

13 (3) APPLICATION TO SETTLEMENTS.—This sub-  
14 section shall apply to an action that is settled as well  
15 as an action that is resolved by a fact finder.

16 **SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.**

17 Any ADR used to resolve a health care liability action  
18 or claim shall contain provisions relating to statute of limi-  
19 tations, non-economic damages, joint and several liability,  
20 punitive damages, collateral source rule, and periodic pay-  
21 ments which are consistent with the provisions relating to  
22 such matters in this title.

23 **SEC. 4014. REPORTING ON FRAUD AND ABUSE ENFORCE-**  
24 **MENT ACTIVITIES.**

25 The General Accounting Office shall—

1 (1) monitor—

2 (A) the compliance of the Department of  
3 Justice and all United States Attorneys with the  
4 guideline entitled “Guidance on the Use of the  
5 False Claims Act in Civil Health Care Matters”  
6 issued by the Department on June 3, 1998, in-  
7 cluding any revisions to that guideline; and

8 (B) the compliance of the Office of the In-  
9 spector General of the Department of Health  
10 and Human Services with the protocols and  
11 guidelines entitled “National Project Proto-  
12 cols—Best Practice Guidelines” issued by the  
13 Inspector General on June 3, 1998, including  
14 any revisions to such protocols and guidelines;  
15 and

16 (2) submit a report on such compliance to the  
17 Committee on Commerce, the Committee on the Ju-  
18 diciary, and the Committee on Ways and Means of  
19 the House of Representatives and the Committee on  
20 the Judiciary and the Committee on Finance of the  
21 Senate not later than February 1, 1999, and every  
22 year thereafter for a period of 4 years ending Feb-  
23 ruary 1, 2002.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

10 “INSPECTION AND COPYING OF PROTECTED HEALTH  
11 INFORMATION

22 “(b) ACCESS THROUGH ORIGINATING PROVIDER.—  
23 Protected health information that is created by an origi-  
24 nating provider, and subsequently received by another  
25 health care provider or a health plan as part of treatment

1 or payment activities, shall be made available for inspec-  
2 tion and copying as provided in this section through the  
3 originating provider, rather than the receiving health care  
4 provider or health plan, unless the originating provider  
5 does not maintain the information.

6 “(c) INVESTIGATIONAL INFORMATION.—With respect  
7 to protected health information that was created as part  
8 of the requesting individual’s participation in a clinical  
9 trial monitored by an institutional review board estab-  
10 lished to review health research with respect to potential  
11 risks to human subjects pursuant to Federal regulations  
12 adopted under section 1802(b) of the Public Health Serv-  
13 ice Act (42 U.S.C. 300v–1(b)) and the notice (informally  
14 referred to as the ‘Common Rule’) promulgated in the  
15 Federal Register at 56 Fed. Reg. 28003), a request under  
16 subsection (a) shall be granted only to the extent and in  
17 a manner consistent with such regulations.

18 “(d) OTHER EXCEPTIONS.—Unless ordered by a  
19 court of competent jurisdiction, a person to whom a re-  
20 quest under subsection (a) is made is not required to grant  
21 the request, if—

22 “(1) the person determines that the disclosure  
23 of the information could reasonably be expected to  
24 endanger the life or physical safety of, or cause sub-  
25 stantial harm to, any individual; or

1 “(2) the information is compiled principally—

2 “(A) in anticipation of a civil, criminal, or  
3 administrative action or proceeding; or

4 “(B) for use in such action or proceeding.

5 “(e) DENIAL OF REQUEST FOR INSPECTION OR  
6 COPYING.—If a person to whom a request under sub-  
7 section (a) is made denies a request for inspection or copy-  
8 ing pursuant to this section, the person shall inform the  
9 individual making the request, in writing, of—

10 “(1) the reasons for the denial of the request;

11 “(2) the availability of procedures for further  
12 review of the denial; and

13 “(3) the individual’s right to file with the per-  
14 son a concise statement setting forth the request.

15 “(f) STATEMENT REGARDING REQUEST.—If an indi-  
16 vidual has filed with a person a statement under sub-  
17 section (e)(3) with respect to protected health information,  
18 the person, in any subsequent disclosure of the informa-  
19 tion—

20 “(1) shall include a notation concerning the in-  
21 dividual’s statement; and

22 “(2) may include a concise statement of the  
23 reasons for denying the request for inspection or  
24 copying.



1       “(g) PROCEDURES.—A person providing access to  
2 protected health information for inspection or copying  
3 under this section may set forth appropriate procedures  
4 to be followed for such inspection or copying and may re-  
5 quire an individual to pay reasonable costs associated with  
6 such inspection or copying.

7       “(h) INSPECTION AND COPYING OF SEGREGABLE  
8 PORTION.—A person to whom a request under subsection  
9 (a) is made shall permit the inspection and copying of any  
10 reasonably segregable portion of a record after deletion of  
11 any portion that the person is not required to disclose  
12 under this section.

13       “(i) DEADLINE.—A person described in subsection  
14 (a) shall comply with or deny, in accordance with this sec-  
15 tion, a request for inspection or copying of protected  
16 health information under this section not later than 30  
17 days after the date on which the person receives the re-  
18 quest.

19       “(j) RULES GOVERNING AGENTS.—An agent of a  
20 person described in subsection (a) shall not be required  
21 to provide for the inspection and copying of protected  
22 health information, except where—

23               “(1) the protected health information is re-  
24       tained by the agent; and

3 “SUPPLEMENTATION OF PROTECTED HEALTH  
4 INFORMATION

5           “SEC. 1182. (a) IN GENERAL.—Subject to subsection  
6 (b), not later than 45 days after the date on which a per-  
7 son who is a health care provider, health plan, employer,  
8 health or life insurer, or educational institution receives,  
9 from an individual who is a subject of protected health  
10 information that is maintained by the person, a request  
11 in writing to amend the information by adding a concise  
12 written supplement to it, the person—

13                   “(1) shall make the amendment requested;

14                   “(2) shall inform the individual of the amend-  
15                   ment that has been made; and

“(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person’s last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

25       “(b) REFUSAL TO AMEND.—If a person described in  
26 subsection (a) refuses to make an amendment requested

1 by an individual under such subsection, the person shall  
2 inform the individual, in writing, of—

3 “(1) the reasons for the refusal to make the  
4 amendment;

5 “(2) any procedures for further review of the  
6 refusal; and

7 “(3) the individual’s right to file with the per-  
8 son a concise statement setting forth the requested  
9 amendment and the individual’s reasons for dis-  
10 agreeing with the refusal.

11 “(c) STATEMENT OF DISAGREEMENT.—If an individ-  
12 ual has filed a statement of disagreement with a person  
13 under subsection (b)(3), the person, in any subsequent dis-  
14 closure of the disputed portion of the information—

15 “(1) shall include a notation that such individ-  
16 ual has filed a statement of disagreement; and

17 “(2) may include a concise statement of the  
18 reasons for not making the requested amendment.

19 “(d) RULES GOVERNING AGENTS.—The agent of a  
20 person described in subsection (a) shall not be required  
21 to make amendments to individually identifiable health in-  
22 formation, except where—

23 “(1) the information is retained by the agent;  
24 and

1           “(2) the agent has been asked by such person  
2           to fulfill the requirements of this section.

3           “(e) DUPLICATIVE REQUESTS FOR AMENDMENTS.—  
4           If a person described in subsection (a) receives a duplica-  
5           tive request for an amendment of information as provided  
6           for in such subsection and a statement of disagreement  
7           with respect to the request has been filed pursuant to sub-  
8           section (c), the person shall inform the individual of such  
9           filing and shall not be required to carry out the procedures  
10          under this section.

11          “(f) RULE OF CONSTRUCTION.—This section shall  
12          not be construed—

13                 “(1) to permit an individual to modify state-  
14                 ments in his or her record that document the factual  
15                 observations of another individual or state the re-  
16                 sults of diagnostic tests; or

17                 “(2) to permit an individual to amend his or  
18                 her record as to the type, duration, or quality of  
19                 treatment the individual believes he or she should  
20                 have been provided.

21          “NOTICE OF CONFIDENTIALITY PRACTICES

22          “SEC. 1183. (a) PREPARATION OF WRITTEN NO-  
23          TICE.—A person who is a health care provider, health  
24          plan, health oversight agency, public health authority, em-  
25          ployer, health or life insurer, health researcher, or edu-  
26          cational institution shall post or provide, in writing and

1 in a clear and conspicuous manner, notice of the person's  
2 protected health information confidentiality practices. The  
3 notice shall include—

4 “(1) a description of an individual's rights with  
5 respect to protected health information;

6 “(2) the intended uses and disclosures of pro-  
7 tected health information;

8 “(3) the procedures established by the person  
9 for the exercise of an individual's rights with respect  
10 to protected health information; and

11 “(4) the procedures established by the person  
12 for obtaining copies of the notice.

13 “(b) MODEL NOTICE.—The Secretary, after notice  
14 and opportunity for public comment, and based on the ad-  
15 vice of the National Committee on Vital and Health Sta-  
16 tistics established under section 306(k) of the Public  
17 Health Service Act (42 U.S.C. 242k(k)), shall develop and  
18 disseminate, not later than 6 months after the date of the  
19 enactment of the Patient Protection Act of 1998, model  
20 notices of confidentiality practices, for use under this sec-  
21 tion. Use of a model notice developed by the Secretary  
22 shall serve as a complete defense in any civil action to an  
23 allegation that a violation of this section has occurred.

24 “ESTABLISHMENT OF SAFEGUARDS

25 “SEC. 1184. (a) IN GENERAL.—A person who is a  
26 health care provider, health plan, health oversight agency,

1 public health authority, employer, health or life insurer,  
2 health researcher, or educational institution shall estab-  
3 lish, maintain, and enforce reasonable and appropriate ad-  
4 ministrative, technical, and physical safeguards to protect  
5 the confidentiality, security, accuracy, and integrity of  
6 protected health information created, received, obtained,  
7 maintained, used, transmitted, or disposed of by the per-  
8 son.

9 “(b) FACTORS TO BE CONSIDERED.—A person sub-  
10 ject to subsection (a) shall consider the following factors  
11 in establishing safeguards under such subsection:

12 “(1) The need for protected health information.

13 “(2) The categories of personnel who will have  
14 access to protected health information.

15 “(3) The feasibility of limiting access to individ-  
16 ual identifiers.

17 “(4) The appropriateness of the policy or proce-  
18 dure to the person, and to the medium in which pro-  
19 tected health information is stored and transmitted.

20 “(5) The value of audit trails in computerized  
21 records.

22 “(c) RELATIONSHIP TO PART C REQUIREMENT.—  
23 Any safeguard established under this section shall be con-  
24 sistent with the requirement in section 1173(d)(2).

1       “(d) CONVERSION TO NONIDENTIFIABLE HEALTH  
2 INFORMATION.—A person subject to subsection (a) shall,  
3 to the extent practicable and consistent with the purpose  
4 for which protected health information is maintained, con-  
5 vert such information into nonidentifiable health informa-  
6 tion.

7       “AVAILABILITY OF PROTECTED HEALTH INFORMATION  
8       FOR PURPOSES OF HEALTH CARE OPERATIONS

9       “SEC. 1185. (a) DISCLOSURE.—Any person who  
10 maintains protected health information may disclose the  
11 information to a health care provider or a health plan for  
12 the purpose of permitting the provider or plan to conduct  
13 health care operations.

14       “(b) USE.—A health care provider or a health plan  
15 that maintains protected health information may use it for  
16 the purposes described in subsection (a).

17       “(c) LIMITATION ON SALE OR BARTER.—Notwith-  
18 standing subsection (b), no health care provider or health  
19 plan may, as part of conducting health care operations,  
20 sell or barter protected health information.

21       “RELATIONSHIP TO OTHER LAWS

22       “SEC. 1186. (a) STATE LAW.—

23       “(1) IN GENERAL.—Except as provided in para-  
24 graphs (2) and (3), the provisions of this part shall  
25 preempt a provision of State law to the extent that  
26 such provision—

1           “(A) otherwise would be preempted as in-  
2           consistent with this part under article VI of the  
3           Constitution of the United States;

4           “(B) relates to authorization for the use or  
5           disclosure of—

6                   “(i) protected health information for  
7                   health care operations; or

8                   “(ii) nonidentifiable health informa-  
9                   tion; or

10          “(C) relates to any of the following:

11                   “(i) Inspection or copying of protected  
12                   health information by a person who is a  
13                   subject of the information.

14                   “(ii) Amendment of protected health  
15                   information by a person who is a subject  
16                   of the information.

17                   “(iii) Notice of confidentiality prac-  
18                   tices with respect to protected health infor-  
19                   mation.

20                   “(iv) Establishment of safeguards for  
21                   protected health information.

22          “(2) EXCEPTIONS.—Nothing in this part shall  
23          be construed to preempt or modify a provision of  
24          State law to the extent that such provision relates  
25          to protected health information and—



1           “(A) the confidentiality of the records  
2 maintained by a licensed mental health profes-  
3 sional;

4           “(B) the provision of health care to a  
5 minor, or the disclosure of information about a  
6 minor to a parent or guardian of the minor;

7           “(C) condition-specific limitations on dis-  
8 closure;

9           “(D) the use or disclosure of information  
10 for use in legally authorized—

11               “(i) disease or injury reporting;

12               “(ii) public health surveillance, inves-  
13 tigation, or intervention;

14               “(iii) vital statistics reporting, such as  
15 reporting of birth or death information;

16               “(iv) reporting of abuse or neglect in-  
17 formation;

18               “(v) reporting of information concern-  
19 ing a communicable disease status; or

20               “(vi) reporting concerning the safety  
21 or effectiveness of a biological product reg-  
22 ulated under section 351 of the Public  
23 Health Service Act (42 U.S.C. 262) or a  
24 drug or device regulated under the Federal

1 Food, Drug, and Cosmetic Act (21 U.S.C.  
2 301 et seq.);

3 “(E) the disclosure to a person by a health  
4 care provider of information about an individ-  
5 ual, in any case in which the provider has de-  
6 termined—

7 “(i) in the provider’s reasonable medi-  
8 cal judgment, that the individual is uncon-  
9 scious, incompetent, or otherwise incapable  
10 of deciding whether to authorize disclosure  
11 of the protected health information; and

12 “(ii) in the provider’s reasonable judg-  
13 ment, that the person is a spouse, relative,  
14 guardian, or close friend of the individ-  
15 ual’s; or

16 “(F) the use of information by, or the dis-  
17 closure of information to, a person holding a  
18 valid and applicable power of attorney that in-  
19 cludes the authority to make health care deci-  
20 sions on behalf of an individual who is a subject  
21 of the information.

22 “(3) PRIVILEGES.—Nothing in this part shall  
23 be construed to preempt or modify a provision of  
24 State law to the extent that such provision relates

1 to a privilege of a witness or other person in a court  
2 of that State.

3 “(b) FEDERAL LAW.—Nothing in this part shall be  
4 construed to preempt, modify, or repeal a provision of any  
5 other Federal law relating to protected health information  
6 or relating to an individual’s access to protected health  
7 information or health care services. Nothing in this part  
8 shall be construed to preempt, modify, or repeal a provi-  
9 sion of Federal law to the extent that such provision re-  
10 lates to a privilege of a witness or other person in a court  
11 of the United States.

12 “CIVIL PENALTIES

13 “SEC. 1187. (a) VIOLATION.—A person who the Sec-  
14 retary determines has substantially and materially failed  
15 to comply with this part shall be subject, in addition to  
16 any other penalties that may be prescribed by law—

17 “(1) in a case in which the violation relates to  
18 section 1181 or 1182, to a civil penalty of not more  
19 than \$500 for each such violation but not to exceed  
20 \$5,000 in the aggregate for all violations of an iden-  
21 tical requirement or prohibition during a calendar  
22 year;

23 “(2) in the case in which the violation relates  
24 to section 1183 or 1184, to a civil penalty of not  
25 more than \$10,000 for each such violation, but not  
26 to exceed \$50,000 in the aggregate for all violations

1 of an identical requirement or prohibition during a  
2 calendar year; or

3 “(3) in a case in which the Secretary finds that  
4 such violations have occurred with such frequency as  
5 to constitute a general business practice, to a civil  
6 penalty of not more than \$100,000.

7 “(b) PROCEDURES FOR IMPOSITION OF PEN-  
8 ALTIES.—Section 1128A, other than subsections (a) and  
9 (b) and the second sentence of subsection (f) of that sec-  
10 tion, shall apply to the imposition of a civil or monetary  
11 penalty under this section in the same manner as such  
12 provisions apply with respect to the imposition of a penalty  
13 under section 1128A.

14 “DEFINITIONS

15 “SEC. 1188. As used in this part:

16 “(1) AGENT.—The term ‘agent’ means a per-  
17 son, including a contractor, who represents and acts  
18 for another under the contract or relation of agency,  
19 or whose function is to bring about, modify, affect,  
20 accept performance of, or terminate contractual obli-  
21 gations between the principal and a third person.

22 “(2) CONDITION-SPECIFIC LIMITATIONS ON DIS-  
23 CLOSURE.—The term ‘condition-specific limitations  
24 on disclosure’ means State laws that prohibit the  
25 disclosure of protected health information relating to

1 a health condition or disease that has been identified  
2 by the Secretary as posing a public health threat.

3 “(3) DISCLOSE.—The term ‘disclose’ means to  
4 release, transfer, provide access to, or otherwise di-  
5 vulge protected health information to any person  
6 other than an individual who is the subject of such  
7 information.

8 “(4) EDUCATIONAL INSTITUTION.—The term  
9 ‘educational institution’ means an institution or  
10 place accredited or licensed for purposes of providing  
11 for instruction or education, including an elementary  
12 school, secondary school, or institution of higher  
13 learning, a college, or an assemblage of colleges  
14 united under one corporate organization or govern-  
15 ment.

16 “(5) EMPLOYER.—The term ‘employer’ has the  
17 meaning given such term under section 3(5) of the  
18 Employee Retirement Income Security Act of 1974  
19 (29 U.S.C. 1002(5)), except that such term shall in-  
20 clude only employers of two or more employees.

21 “(6) HEALTH CARE.—The term ‘health care’  
22 means—

23 “(A) preventive, diagnostic, therapeutic,  
24 rehabilitative, maintenance, or palliative care,  
25 including appropriate assistance with disease or

1 symptom management and maintenance, coun-  
2 seling, service, or procedure—

3 “(i) with respect to the physical or  
4 mental condition of an individual; or

5 “(ii) affecting the structure or func-  
6 tion of the human body or any part of the  
7 human body, including the banking of  
8 blood, sperm, organs, or any other tissue;  
9 or

10 “(B) any sale or dispensing, pursuant to a  
11 prescription or medical order, of a drug, device,  
12 equipment, or other health care-related item to  
13 an individual, or for the use of an individual.

14 “(7) HEALTH CARE OPERATIONS.—The term  
15 ‘health care operations’ means services, provided di-  
16 rectly by or on behalf of a health plan or health care  
17 provider or by its agent, for any of the following  
18 purposes:

19 “(A) Coordinating health care, including  
20 health care management of the individual  
21 through risk assessment, case management, and  
22 disease management.

23 “(B) Conducting quality assessment and  
24 improvement activities, including outcomes eval-

1           uation, clinical guideline development and im-  
2           provement, and health promotion.

3           “(C) Carrying out utilization review activi-  
4           ties, including precertification and  
5           preauthorization of services, and health plan  
6           rating activities, including underwriting and ex-  
7           perience rating.

8           “(D) Conducting or arranging for auditing  
9           services.

10          “(8) HEALTH CARE PROVIDER.—The term  
11          ‘health care provider’ means a person, who with re-  
12          spect to a specific item of protected health informa-  
13          tion, receives, creates, uses, maintains, or discloses  
14          the information while acting in whole or in part in  
15          the capacity of—

16               “(A) a person who is licensed, certified,  
17               registered, or otherwise authorized by Federal  
18               or State law to provide an item or service that  
19               constitutes health care in the ordinary course of  
20               business, or practice of a profession;

21               “(B) a Federal, State, or employer-spon-  
22               sored or any other privately-sponsored program  
23               that directly provides items or services that con-  
24               stitute health care to beneficiaries; or

1           “(C) an officer or employee of a person de-  
2           scribed in subparagraph (A) or (B).

3           “(9) HEALTH OR LIFE INSURER.—The term  
4           ‘health or life insurer’ means a health insurance  
5           issuer, as defined in section 9832(b)(2) of the Inter-  
6           nal Revenue Code of 1986, or a life insurance com-  
7           pany, as defined in section 816 of such Code.

8           “(10) HEALTH PLAN.—The term ‘health plan’  
9           means any health insurance plan, including any hos-  
10          pital or medical service plan, dental or other health  
11          service plan, health maintenance organization plan,  
12          plan offered by a provider-sponsored organization  
13          (as defined in section 1855(d)), or other program  
14          providing or arranging for the provision of health  
15          benefits.

16          “(11) HEALTH RESEARCHER.—The term  
17          ‘health researcher’ means a person (or an officer,  
18          employee, or agent of a person) who is engaged in  
19          systematic investigation, including research develop-  
20          ment, testing, data analysis, and evaluation, de-  
21          signed to develop or contribute to generalizable  
22          knowledge relating to basic biomedical processes,  
23          health, health care, health care delivery, or health  
24          care cost.



1           “(12) NONIDENTIFIABLE HEALTH INFORMA-  
2           TION.—The term ‘nonidentifiable health information’  
3           means protected health information from which per-  
4           sonal identifiers that reveal the identity of the indi-  
5           vidual who is the subject of such information or pro-  
6           vide a direct means of identifying the individual  
7           (such as name, address, and social security number)  
8           have been removed, encrypted, or replaced with a  
9           code, such that the identity of the individual is not  
10          evident without (in the case of encrypted or coded  
11          information) use of a key.

12          “(13) ORIGINATING PROVIDER.—The term  
13          ‘originating provider’, when used with respect to  
14          protected health information, means the health care  
15          provider who takes an action that initiates the treat-  
16          ment episode to which that information relates, such  
17          as prescribing a drug, ordering a diagnostic test, or  
18          admitting an individual to a health care facility. A  
19          hospital or nursing facility is the originating pro-  
20          vider with respect to protected health information  
21          created or received as part of inpatient or outpatient  
22          treatment provided in the hospital or facility.

23          “(14) PAYMENT ACTIVITIES.—The term ‘pay-  
24          ment activities’ means—

25                 “(A) activities undertaken—

1 “(i) by, or on behalf of, a health plan  
2 to determine its responsibility for coverage  
3 under the plan; or

4 “(ii) by a health care provider to ob-  
5 tain payment for items or services provided  
6 to an individual, provided under a health  
7 plan, or provided based on a determination  
8 by the health plan of responsibility for cov-  
9 erage under the plan; and

10 “(B) includes the following activities, when  
11 performed in a manner consistent with subpara-  
12 graph (A):

13 “(i) Billing, claims management, med-  
14 ical data processing, other administrative  
15 services, and actual payment.

16 “(ii) Determinations of coverage or  
17 adjudication of health benefit or subroga-  
18 tion claims.

19 “(iii) Review of health care services  
20 with respect to coverage under a health  
21 plan or justification of charges.

22 “(15) PERSON.—The term ‘person’ means—

23 “(A) a natural person;

24 “(B) a government or governmental sub-  
25 division, agency, or authority;

1           “(C) a company, corporation, estate, firm,  
2           trust, partnership, association, joint venture,  
3           society, or joint stock company; or

4           “(D) any other legal entity.

5           “(16) PROTECTED HEALTH INFORMATION.—

6           The term ‘protected health information’, when used  
7           with respect to an individual who is a subject of in-  
8           formation means any information (including genetic  
9           information) that identifies the individual, whether  
10          oral or recorded in any form or medium, and that—

11          “(A) is created or received by a health care  
12          provider, health plan, health oversight agency,  
13          public health authority, employer, health or life  
14          insurer, or educational institution;

15          “(B) relates to the past, present, or future  
16          physical or mental health or condition of an in-  
17          dividual (including individual cells and their  
18          components);

19          “(C) is derived from—

20                  “(i) the provision of health care to an  
21                  individual; or

22                  “(ii) payment for the provision of  
23                  health care to an individual; and

24          “(D) is not nonidentifiable health informa-  
25          tion.

1           “(17) STATE.—The term ‘State’ includes the  
2       District of Columbia, Puerto Rico, the Virgin Is-  
3       lands, Guam, American Samoa, and the Northern  
4       Mariana Islands.

5           “(18) TREATMENT.—The term ‘treatment’  
6       means the provision of health care by a health care  
7       provider.

8           “(19) WRITING.—The term ‘writing’ means  
9       writing either in a paper-based, computer-based, or  
10      electronic form, including electronic signatures.”.

11      (b) ENFORCEMENT OF PROVISIONS THROUGH CON-  
12      DITIONS ON PARTICIPATION.—

13           (1) PARTICIPATING PHYSICIANS AND SUPPLI-  
14      ERS.—Section 1842(h) of the Social Security Act  
15      (42 U.S.C. 1395u(h)) is amended by adding at the  
16      end the following:

17      “(9) The Secretary may refuse to enter into an agree-  
18      ment with a physician or supplier under this subsection,  
19      or may terminate or refuse to renew such agreement, in  
20      the event that such physician or supplier has been found  
21      to have violated a provision of part D of title XI.”.

22           (2) MEDICARE+CHOICE ORGANIZATIONS.—Sec-  
23      tion 1852(h) of the Social Security Act (42 U.S.C.  
24      1395w–22(h)) is amended—

1 (A) in the matter preceding paragraph (1),  
2 by striking “procedures—” and inserting “pro-  
3 cedures, consistent with sections 1181 through  
4 1185—”; and

5 (B) in paragraph (1), by striking “privacy  
6 of any individually identifiable enrollee informa-  
7 tion;” and inserting “confidentiality of pro-  
8 tected health information concerning enroll-  
9 ees;”.

10 (3) MEDICARE PROVIDERS.—Section  
11 1866(a)(1) of the Social Security Act (42 U.S.C.  
12 1395cc(a)(1)) is amended—

13 (A) by inserting a semicolon at the end of  
14 subparagraph (R);

15 (B) by striking the period at the end of  
16 subparagraph (S) and inserting “; and”; and

17 (C) by inserting immediately after sub-  
18 paragraph (S) the following new subparagraph:

19 “(T) to comply with sections 1181 through  
20 1184.”.

21 (4) HEALTH MAINTENANCE ORGANIZATIONS  
22 WITH RISK-SHARING CONTRACTS.—Section  
23 1876(k)(4) of the Social Security Act (42 U.S.C.  
24 1395mm(k)(4)) of the Social Security Act is amend-  
25 ed by adding at the end the following:

1           “(E) The confidentiality and accuracy proce-  
2           dure requirements under section 1852(h).”.

3           (c) CONFORMING AMENDMENTS.—

4           (1) TITLE HEADING.—Title XI of the Social  
5           Security Act (42 U.S.C. 1301 et seq.) is amended by  
6           striking the title heading and inserting the following:  
7           “TITLE XI—GENERAL PROVISIONS, PEER RE-  
8           VIEW, ADMINISTRATIVE SIMPLIFICATION,  
9           AND CONFIDENTIALITY OF PROTECTED  
10          HEALTH INFORMATION”.

11          (2) NATIONAL COMMITTEE ON VITAL AND  
12          HEALTH STATISTICS.—Section 306(k)(5) of the  
13          Public Health Service Act (42 U.S.C. 242(k)(5)) is  
14          amended—

15                 (A) in subparagraphs (A)(viii) and (D), by  
16                 striking “part C” and inserting “parts C and  
17                 D”;

18                 (B) in subparagraph (C), by striking  
19                 “and” at the end;

20                 (C) in subparagraph (D), by striking the  
21                 period at the end and inserting “; and”; and

22                 (D) by adding at the end the following:

23                 “(E) shall study the issues relating to section  
24                 1184 of the Social Security Act (as added by the Pa-  
25                 tient Protection Act of 1998), and, not later than 1

1 year after the date of the enactment of the Patient  
2 Protection Act of 1998, shall report to the Congress  
3 on such section.”.

4 (d) EFFECTIVE DATE.—The amendments made by  
5 this section shall take effect on the date that is 1 year  
6 after the date of the enactment of this Act, except that  
7 subsection (c)(2), and section 1183(b) of the Social Secu-  
8 rity Act (as added by subsection (a)), shall take effect on  
9 the date of the enactment of this Act.

10 **SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW**  
11 **ON HEALTH-RELATED RESEARCH.**

12 Not later than 1 year after the date of the enactment  
13 of this Act, the Comptroller General of the United States  
14 shall prepare and submit to the Congress a report contain-  
15 ing the results of a study on the effect of State laws on  
16 health-related research subject to review by an institu-  
17 tional review board or institutional review committee with  
18 respect to the protection of human subjects.

19 **SEC. 5003. STUDY AND REPORT ON STATE LAW ON PRO-**  
20 **TECTED HEALTH INFORMATION.**

21 (a) IN GENERAL.—Not later than 9 months after the  
22 date of the enactment of this Act, the Comptroller General  
23 of the United States shall prepare and submit to the Con-  
24 gress a report containing the results of a study—

1           (1) compiling State laws on the confidentiality  
2           of protected health information (as defined in sec-  
3           tion 1188 of the Social Security Act, as added by  
4           section 5001 of this Act); and

5           (2) analyzing the effect of such laws on the pro-  
6           vision of health care and securing payment for such  
7           care.

8           (b)    MODIFICATION    OF    DEADLINE.—Section  
9   264(c)(1) of the Health Insurance Portability and Ac-  
10   countability Act of 1996 (Public Law 104–191; 110 Stat.  
11   2033) is amended by striking “36 months after the date  
12   of the enactment of this Act,” and inserting “6 months  
13   after the date on which the Comptroller General of the  
14   United States submits to the Congress a report under sec-  
15   tion 5003(a) of the Patient Protection Act of 1998,”.

16   **SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DE-**  
17                   **VELOPED TO REDUCE MORTALITY OR MOR-**  
18                   **BIDITY OR FOR IMPROVING PATIENT CARE**  
19                   **AND SAFETY.**

20           (a) PROTECTION OF CERTAIN INFORMATION.—Not-  
21   withstanding any other provision of Federal or State law,  
22   health care response information shall be exempt from any  
23   disclosure requirement (regardless of whether the require-  
24   ment relates to subpoenas, discovery, introduction of evi-  
25   dence, testimony, or any other form of disclosure), in con-



1 nection with a civil or administrative proceeding under  
2 Federal or State law, to the same extent as information  
3 developed by a health care provider with respect to any  
4 of the following:

5 (1) Peer review.

6 (2) Utilization review.

7 (3) Quality management or improvement.

8 (4) Quality control.

9 (5) Risk management.

10 (6) Internal review for purposes of reducing  
11 mortality, morbidity, or for improving patient care  
12 or safety.

13 (b) NO WAIVER OF PROTECTION THROUGH INTER-  
14 ACTION WITH ACCREDITING BODY.—Notwithstanding any  
15 other provision of Federal or State law, the protection of  
16 health care response information from disclosure provided  
17 under subsection (a) shall not be deemed to be modified  
18 or in any way waived by—

19 (1) the development of such information in con-  
20 nection with a request or requirement of an accredit-  
21 ing body; or

22 (2) the transfer of such information to an ac-  
23 crediting body.

24 (c) DEFINITIONS.—For purposes of this section:

1           (1) The term “accrediting body” means a na-  
2           tional, not-for-profit organization that—

3                   (A) accredits health care providers; and

4                   (B) is recognized as an accrediting body by  
5           statute or by a Federal or State agency that  
6           regulates health care providers.

7           (2) The term “health care provider” has the  
8           meaning given such term in section 1188 of the So-  
9           cial Security Act (as added by section 5001 of this  
10          Act).

11          (3) The term “health care response informa-  
12          tion” means information (including any data, report,  
13          record, memorandum, analysis, statement, or other  
14          communication) developed by, or on behalf of, a  
15          health care provider in response to a serious, ad-  
16          verse, patient-related event—

17                   (A) during the course of analyzing or  
18                   studying the event and its causes; and

19                   (B) for purposes of—

20                           (i) reducing mortality or morbidity; or

21                           (ii) improving patient care or safety  
22                   (including the provider’s notification to an  
23                   accrediting body and the provider’s plans  
24                   of action in response to such event).

1           (5) The term “State” has the meaning given  
2           such term in section 1188 of the Social Security Act  
3           (as added by section 5001 of this Act).

4 **SEC. 5005. EFFECTIVE DATE FOR STANDARDS GOVERNING**  
5 **UNIQUE HEALTH IDENTIFIERS FOR INDIVID-**  
6 **UALS.**

7           Section 1174 of the Social Security Act (42 U.S.C.  
8 1320d–3) is amended by adding at the end the following:  
9           “(c) UNIQUE HEALTH IDENTIFIERS.—Notwithstand-  
10 ing subsections (a) and (b), the Secretary may not promul-  
11 gate or adopt a final standard under section 1173(b) pro-  
12 viding for a unique health identifier for an individual (ex-  
13 cept in an individual’s capacity as an employer or a health  
14 care provider), until legislation is enacted specifically ap-  
15 proving the standard or containing provisions consistent  
16 with the standard.”.

          Passed the House of Representatives July 24, 1998.

Attest:

*Clerk.*